COMMITTEE ON THE BUDGET
MAJORITY CAUCUS
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# REVIVING THE REFORM AGENDA

## THE URGENT NEED TO ADDRESS GOVERNMENT WASTE, FRAUD, ABUSE, AND MISMANAGEMENT

**A REPORT BY THE**
**House Committee on the Budget**
**Majority Caucus**

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**CHAIRMAN**
**INSIDE MAIL**

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# INTRODUCTION

Fraud, waste, abuse, and mismanagement undermine the effectiveness of Government programs, cost taxpayers billions in lost and wasted dollars, and deprive programs and beneficiaries of resources they are intended to receive. When such problems are chronic, they also jeopardize the credibility of a Government that spends about $1.8 trillion a year.

Nevertheless, Federal programs continue to waste billions of dollars annually through longstanding, systemic problems that persist – and in some cases are growing worse – despite repeated warnings from the Government's principal watchdogs, the General Accounting Office [GAO] and the inspectors general [IG] of Government agencies. This report summarizes several years of work by these watchdogs, as well as other sources, with respect to the Government's largest programs and agencies. It also provides numerous examples of the wasteful spending that results from continuing Government mismanagement. Many of the examples are from reports published in 1999; others are from prior years. The combination shows that the same problems recur year after year – because the underlying causes remain.

By highlighting these continuing problems, this report aims at renewing attention to accountability and responsible stewardship of Government programs. It aims – to put it simply – at reviving a reform agenda for the Government.

Although each of the programs discussed in this report has problems unique to itself, certain broad failures appear throughout. These include billions of dollars in improper Government payments; programs at high risk of waste, abuse, and mismanagement; a lack of financial accountability; and the persistence of fraud from both inside and outside the Government. The rest of this introduction reviews these broader issues. This report also contains an addendum concerning duplication and fragmentation in Government programs.

## IMPROPER GOVERNMENT PAYMENTS

This past October, in a report on the Government's financial management, GAO cited $19.1 billion in improper Government payments for fiscal year 1998. But the widely cited figure – applying to 17 major programs that spent about $870 billion – actually *under*states the size of the problem. It accounts only for the improper payments that could be quantified (see chart on the next page). In fact, GAO said: "Improper payments are much greater than have been disclosed thus far." (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

To support this view, GAO's report noted the following:

< The Agency for International Development, the Medicaid Program, and the Federal Crop Insurance Corporation all acknowledged improper payments, but did not disclose the amounts.

< In fiscal years 1994 through 1998, Department of Defense contractors returned $984 million that the Government erroneously paid to them.

< In a review of 290,000 Earned Income Credit [EIC] tax returns with indications of errors or irregularities, the Internal Revenue Service [IRS] found that $448 million (68 percent of the $662 million claimed) was invalid for fiscal year 1998.

## $19.1 Billion in Improper Payments

| | |
|---|---|
| Medicare | $12.6 Billion |
| Supplemental Security Income | $1.6 Billion |
| The Food Stamp Program | $1.4 Billion |
| Old Age and Survivors Insurance | $1.2 Billion |
| Disability Insurance | $941 Million |
| Housing Subsidies | $857 Million |
| Veterans Benefits, Unemployment Insurance, and Others | $514 Million |

Source: GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Payments*, October 1999.

In addition, many Federal programs share key characteristics with those listed above – complex regulations, an emphasis on swift payments, and a large volume of transactions – and hence also risk making improper payments, GAO said. The problem is worsened because Government agencies do not perform comprehensive reviews of their payment methods. As a result, GAO said, "the full extent of the Government's improper payments is not known." (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

### PROGRAMS AND AGENCIES REMAIN AT "HIGH RISK"

Since 1990, GAO has identified programs and agencies considered at "high risk" for waste, fraud, abuse, and mismanagement. The problem areas cut across virtually every part of the Government, and most remain at high risk year after year (see chart on the next page).

*The list is still growing*. Although the Government apparently resolved most of its Y2K computer conversion problems – which had been deemed high risk in 1997 – a summary of the remaining high-risk designations reveals the following:

< Ten of the 14 programs first identified as high risk in 1990 were still at high risk in GAO's most recent assessment.

< Fifteen programs have been added to the list since 1993.

< A total of 19 programs have been high risk for 4 years or more.

< Since 1995, the financial management operations of four major agencies – the Department of Defense, the Forest Service, the Federal Aviation Administration, and the Internal Revenue Service – have been added to the high-risk list.

## 1999 High-Risk Areas and the Year They Were Designated High Risk

| | |
|---|---|
| **Managing Large Procurement Operations More Efficiently** | |
| • *DOD Inventory Management* | *1990* |
| • *DOD Weapon Systems Acquisition* | *1990* |
| • *DOD Contract Management* | *1992* |
| • *Department of Energy Contract Management* | *1990* |
| • *Superfund Contract Management* | *1990* |
| • *NASA Contract Management* | *1990* |
| **Reducing Inordinate Program Management Risks** | |
| • *Medicare* | *1990* |
| • *Supplemental Security Income* | *1997* |
| • *IRS Tax Filing Fraud* | *1995* |
| • *DOD Infrastructure Management* | *1997* |
| • *HUD Programs* | *1994* |
| • *Student Financial Aid Programs* | *1990* |
| • *Farm Loan Programs* | *1990* |
| • *Asset Forfeiture Programs* | *1990* |
| • *The 2000 Census* | *1997* |
| **Ensuring Major Technology Investments Improve Services** | |
| • *Air Traffic Control Modernization* | *1995* |
| • *Tax Systems Modernization* | *1995* |
| • *National Weather Service Modernization* | *1995* |
| • *DOD Systems Development and Modernization Efforts* | *1995* |
| **Providing Basic Financial Accountability** | |
| • *DOD Financial Management* | *1995* |
| • *Forest Service Financial Management* | *1999* |
| • *FAA Financial Management* | *1999* |
| • *IRS Financial Management* | *1995* |
| • *IRS Receivables* | *1990* |
| **Resolving Serious Information Security Weaknesses** | *1997* |
| **Addressing Urgent Year 2000 Computing Challenge** | *1997* |

Source: GAO/HR-99-1 High-Risk Update, January 1999.

## LACK OF FINANCIAL ACCOUNTABILITY

In the words of Representative Pete Hoekstra, an audit of an agency's financial records is "like making sure your shoes are tied, so you don't trip." If an agency handles its money properly, "there is less chance of taxpayer dollars being lost to waste, fraud, and abuse."

By these terms, the shoes of many Government agencies – as well as the Government as a whole – have been left *un*tied.

The most recent audits, for fiscal year 1998, showed that six major agencies – the Departments of Agriculture, Defense, Education, Justice, and Transportation, and the Agency for International Development – *could not provide financial statements that reliably account for the hundreds of billions of dollars they spent*. Put another way, these agencies failed to produce the kinds of financial records that the Government requires of every private-sector company that trades its stock publicly.

A striking example, which shows no signs of improving, is the Department of Defense [DOD]. In a December 1999 summary, the IG reported that DOD's financial statements were "less timely than ever," and that they contained "a record $1.7 trillion of unsupported adjustments" – an amount roughly the same as the entire Federal budget. The IG also cited "problems related to cash management" in the DOD working capital funds, "inaccurate or untimely recording of obligations and disbursements," and "vulnerability to fraud." The IG concluded: "DOD does not expect a significant difference in the overall results of financial statement audits for several more years." (Department of Defense IG, *Detailed Response to Congressional Request of September 22, 1999 on DOD Management Challenges*, 15 December 1999)

The fiscal year 1998 financial statements for the Government overall were also deemed unreliable. GAO's audit specified – among other problems – that the Government cannot:

- Properly account for billions of dollars of property, equipment, materials, and supplies.
- Properly estimate the cost of most major Federal credit programs and related loans receivable and loan guarantee liabilities.
- Estimate and reliably report amounts of environmental and disposal liabilities and reported costs.
- Determine amounts of Government liabilities such as health benefits for retired military employees.
- Determine the full extent of the billions in improper payments through Government programs.

Said GAO: "[S]ignificant financial systems weaknesses, problems with fundamental recordkeeping and financial reporting, incomplete documentation, and weak internal controls,

including computer controls, continue to prevent the Government from accurately reporting a significant portion of its assets, liabilities, and costs . . . They also affect the Government's ability . . . to manage its programs." (GAO, *Financial Audit: 1998 Financial Report of the United States Government*, March 1999)

## FRAUD

Fraud continues to pervade many large Government programs. Among the examples cited in this report are the following:

< **The Earned Income Credit [EIC]** – GAO reports that this credit "has historically been vulnerable to high rates of invalid claims." As recently as December 1999, the Treasury Department's inspector general cited "scams" and "conspiracies" in which hundreds of taxpayers' Social Security numbers were used to perpetrate EIC fraud.

< **Food Stamps** – Because food stamps are a kind of parallel currency, they are subject to "trafficking" among a variety of businesses, or exchanged by beneficiaries for cash to buy cigarettes, toys, clothing, or other nonfood items.

< **Supplemental Security Income [SSI]** – This cash assistance program is frequently defrauded by persons who misrepresent their income to qualify for benefits; by malingerers who falsely claim disabilities to obtain benefits; and by unscrupulous doctors and lawyers who vouch for false claimants.

Other examples include the Federal Employees Health Benefits Program, estimated to consume as much as $1.8 billion a year in waste, fraud, and abuse (Office of Personnel Management IG, *Most Serious Management Problems: Office of Personnel Management*, 1 December 1999); and Unemployment Insurance [UI], which is subject to various abuses, including "fraudulent employer schemes, internal embezzlement schemes, and the fraudulent collection of UI benefits by illegal aliens using counterfeit or unissued Social Security numbers." (Department of Labor IG, *U.S. Department of Labor: Top Management Issues*, 8 December 1999)

But in the Government's medical programs, fraud has taken on a new form. According to an October 1999 GAO report, Medicare and Medicaid have attracted their own class of criminals, who specialize in defrauding these Government programs, as well as private-sector health insurance. "While the full extent of the problem remains unknown," GAO said, "we did determine that career criminal and organized criminal groups are involved in Medicare, Medicaid, and private insurance health care fraud or alleged fraud throughout the country." (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

Compounding the problem is the Government's own laxity in monitoring and oversight of these programs. This environment "permitted unscrupulous providers opportunities to obtain

additional unjustified payments," GAO said. In other words, the Government itself bears at least some responsibility for the fraud perpetrated against its own programs. As GAO put it: "The lack of sufficient oversight and monitoring controls can lead to improper payments by fostering an atmosphere that invites fraud." (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

## CONCLUSION

House Majority Leader Richard K. Armey has said: "Every dollar spent by the Government is a dollar earned by someone else. Taxpayers deserve a Government that doesn't waste their hard-earned dollars." But as noted at the outset, fraud, waste, abuse, and mismanagement continue to cost taxpayers billions in lost and wasted dollars. They also cost Government programs and beneficiaries the support they are intended to receive.

These problems are the focus of this report. It underscores repeated warnings of the inspectors general, the General Accounting Office, and other watchdogs. It shows that considerable work still needs to be done to address – and ultimately to correct – these longstanding, systemic problems. It aims at renewing a concern for accountability and stewardship in the Government – and at reviving an ongoing agenda of reform.

# EXECUTIVE SUMMARY

## NATIONAL DEFENSE

< Wasteful spending saps the readiness of the Nation's Forces, weakening national security. The General Accounting Office [GAO], the Pentagon's own inspector general [IG], and other watchdog groups have found flagrant and continuing examples of waste, fraud, and abuse in the Department of Defense [DOD]. These failures divert funds from vital defense programs.

< DOD is the largest holder of Federal Government assets, at $1.3 trillion, and is the Nation's largest employer – with an all-volunteer Force that includes 1.4 million persons on active duty, 705,000 civilians, and another 1.35 million serving in the National Guard and Reserve.

< GAO has designated the following four Pentagon activities as "high risk," reflecting an extraordinarily high amount of management shortfalls, flawed processes, and cost overruns. These areas are the following:

- **Financial Management** – According to the Department's inspector general [IG], *DOD's financial accountability has been growing worse*. Its most recent financial statements (for fiscal year 1998) were more untimely than ever, and a record $1.7 trillion of unsupported adjustments were made in preparing the statements. In addition, DOD is responsible for almost half of the Government's general plant, property, and equipment – but billions of dollars of its property valuation is unreliable.

- **Acquisition Problems** – The Department continues to suffer from longstanding acquisition problems, leading to costly errors in purchasing and inflated prices. The IG has described DOD's procurement practices as "poorly conceived" and "badly coordinated," and said the Department "has not yet learned how to be an astute buyer in the commercial marketplace."

- **Inventory Problems** – Inventory management problems have plagued the Pentagon for decades, and continue creating large surpluses and shortages of inventory. At times, officials have been unable to locate equipment such as landing craft, aircraft engines, and missile launchers. Excess inventories also result in unnecessary storage costs.

- **Infrastructure** – The Armed Forces are top-heavy with uniformed supervisors, staff officers, chiefs, deputies, and directors – yet some services have continued asking for more top-level officers.

## HOUSING AND URBAN DEVELOPMENT

< Since its creation in 1965, the Department of Housing and Urban Development [HUD] has spent $500 billion, supposedly to provide low-income people with decent, safe, and sanitary housing.

< But these funds have often bought the opposite of what was intended. Among the results have been the following:

- **Troubled Neighborhoods** – HUD's public and assisted housing projects have become nests of violent crime and drug trafficking.

- **Waste, Fraud, and Abuse** – Since 1994, the General Accounting Office [GAO] has termed HUD a "high-risk" agency – meaning it is exceptionally vulnerable to waste, fraud, and abuse. It is the *only Cabinet-level agency* to hold the designation. An example of the problem: HUD itself estimates that nearly $1 of every $18 it spends in its section 8 assisted housing program is wasted. HUD also has failed to provide timely and effective enforcement against those who defraud the system.

- **Deteriorating Housing** – While HUD's Federal Housing Administration [FHA] has sought to extend mortgage insurance to persons unable to obtain home loans in the private market, it often has failed to assure properties are in good condition, or to provide needed financial counseling so buyers can keep up with their mortgage payments. Properties left abandoned after defaults are allowed to run down, or be taken over by drug dealers – and this decay, in turn, infects surrounding neighborhoods.

- **Mismanagement** – HUD's own mismanagement is a major contributor to the problems listed above. HUD programs continue to proliferate while its shrinking staff remains poorly matched to program management and oversight. Furthermore, HUD's 3-year-old restructuring plan – a major undertaking known as HUD 2020 – *appears to be making matters worse*.

< HUD's own officials have acknowledged the severity of the Department's problems: "[Its] failings have made HUD the poster child for inept Government," says the executive summary of HUD's Management Reform Plan.

## MEDICARE

< In the most recent semiannual report of her Department's inspector general, Health and Human Services Secretary Donna E. Shalala wrote: "Fraud, waste, and abuse threaten to undermine the effectiveness of [the Department's] programs, cost taxpayers billions in lost and wasted dollars, and deprive vulnerable beneficiaries of the care and support they need."

< Yet in the Department's largest program – Medicare – waste, fraud, and abuse persist, coupled with longstanding, systemic problems in the way the program is run. The General Accounting Office [GAO] has retained Medicare on its list of "high-risk" programs, meaning it is exceptionally vulnerable to fraud and abuse. Some key problems include the following:

- **Improper Payments** – Medicare's fee-for-service program made $12.6 billion in improper payments in fiscal year 1998, the most recent year analyzed. Although this appeared to be better than the previous year, the improvement was mainly the result of better paperwork, rather than changes in actual billing practices.

- **Fraud** – The improper payments quantified cannot account for the substantial fraud the program suffers. Indeed, recent accounts show that Medicare has attracted its own class of organized criminals – persons who specialize in defrauding health care and health insurance systems.

- **Mismanagement** – Program administrators have failed to provide sufficient safeguards and oversight to assure Medicare funds are properly spent.

- **Flawed Payment Mechanisms** – Medicare grossly overpays for some services because of the nature of its own payment mechanisms – but the total amount of these excessive payments has not been quantified.

## MEDICAID

< Medicaid, along with Medicare and private health insurance, is being victimized by a special class of criminals who target these systems. These criminal enterprises thrive by "brokering" beneficiary information, fraudulent billing, kickback schemes involving clinics, and by creating bogus medical suppliers.

< In one of the most dramatic examples of this practice, the State of California's Medicaid program was defrauded of amounts that may exceed $1 billion – the worst fraud against a State in American history.

< Yet, in the face of what appears to be rampant Medicaid fraud, the Federal Government has not even tried to determine the amount of improper payments – through fraud or other problems – occurring in the Medicaid Program.

< According to an October 1999 GAO report: "The Health Care Financing Administration [the agency responsible for overseeing the Medicaid Program] has no comprehensive quality assurance program or other methodology in place for estimating improper Medicaid payments."

## FOOD STAMPS AND OTHER NUTRITION PROGRAMS

### The Food Stamp Program

< The Food Stamp Program made an estimated $1.4 billion in improper payments in 1998. This finding corresponds with similar findings by the General Accounting Office [GAO]. A January 1999 GAO study reported that, in addition to millions of dollars in overpayments and payments to ineligible persons, benefits were being sent to prisoners and deceased individuals.

< Because food stamps are a kind of parallel currency, they are subject to fraud and misuse by beneficiaries, vendors, or others who may handle them.

- Some recipients exchange their food stamp benefits for ineligible products such as cigarettes.

- Some recipients trade food stamps for cash to buy items such as clothing, toys, or other consumer goods.

- Illegally used food stamps obtained by vendors can be "trafficked" among a variety of businesses, who exchange the stamps at increasingly higher values until an approved vendor redeems them.

- Because food stamp eligibility is based on income, some people misrepresent their economic status to qualify for benefits. The practice may range from simply failing to disclose income to misrepresenting the size and composition of a household.

### The Child and Adult Care Food Program [CACFP]

< CACFP provides meals and snacks to low-income children in child care, including those in home day care settings.

< The program is run by State education departments, which (except Virginia) delegate management of the home day care program to sponsors, who recruit providers to participate.

- Although the States receive a portion of $100 million to conduct oversight of sponsors, few States have actually used the funds for oversight.

- CACFP relies on the trustworthiness of sponsors, and – because it is completely federally funded – States have no incentive to examine sponsors for abuse. This combination makes the program highly vulnerable to fraud, including the creation of "phantom" sponsors.

**Other Child Nutrition Programs**

< The National School Lunch Program provides free or reduced price meals to low-income children; the Summer Feeding Program essentially continues the mission of the school lunch program when school is not in session. Both are rife with waste and fraud, totaling in the millions of dollars.

< Eligibility for the school lunch program is based on a system that relies on families truthfully representing their incomes when applying for the subsidy. Those seeking to defraud the program face very little change of being detected.

< The summer feeding program shares a weakness similar to the CACFP program mentioned above – it is administered by sponsors. In the absence of proper scrutiny, persons wishing to cheat the program can do so.

**SUPPLEMENTAL SECURITY INCOME [SSI]**

< An October GAO study reported overpayments of $1.6 billion in both 1996 and 1998. In addition, GAO reports that SSI administrators have chronically failed to recover outstanding overpayments, now totaling about $4 billion.

< These substantial overpayments are one reason SSI is on GAO's "high-risk" list – meaning it is exceptionally vulnerable to waste, fraud, abuse, and mismanagement.

< Many beneficiaries fail to disclose assets and other income that might disqualify them for benefits. In addition, certain persons who are ineligible for benefits – such as prisoners and persons who no longer live in the United States – continue to receive benefits because they fail to notify SSI staff of their status.

< The problems are aggravated by the failure of SSI staff to treat benefits with the same scrutiny applied to other welfare programs.

**THE EARNED INCOME CREDIT [EIC]**

< Because the credit relies on taxpayer-provided information, the program has become highly subject to fraud.

< An IRS audit of 1995 tax returns (for the tax year 1994) claiming the EIC found $4.4 billion in overpayments – out of $17.2 billion in total claims. A followup study by the IRS determined that, even after the implementation of compliance reforms, the error rate was still at least 20 percent of all EIC claims filed.

< In October 1999, the GAO reported that during fiscal year 1998, IRS examiners reviewed 290,000 EIC tax returns with indications of errors or irregularities. A staggering $448 million (68 percent of the total $662 million claimed) was found to be invalid during fiscal year 1998.

< Information about EIC fraud can only be detected through the tax auditing process. This creates a substantial time lag before investigators can verify abuses; and obtaining current information about abuse of the credit is difficult.

**Addendum**
**FRAGMENTATION AND DUPLICATION**

< The problems of fragmented and duplicative Government activities is apparent in food safety.

- As many as 12 different Federal agencies administer more than 35 different laws overseeing food safety.

- In addition, subtle differences in food products dictate which agency regulates a product.

< GAO has said: "In program after program, we have found that unfocused and uncoordinated crosscutting programs waste scarce funds, confuse and frustrate taxpayers and other program customers, and limit overall program effectiveness."

< Other areas of continuing fragmentation and duplication include the following:

- **Economic Development** – GAO has identified 342 different economic development programs, some of which "are similar enough to be potential candidates for merger or elimination."

- **The Department of Commerce** – The Department today shares missions with at least 71 other Federal departments, agencies, and offices. GAO has characterized the Department as "a large 'holding company' composed of 12

operating bureaus, each pursuing disparate programs and activities that cut across several Federal functions." Budget resolutions in both the 104th and 105th Congresses called for eliminating the Department.

- **Education** – The comprehensive *Education at a Crossroads* project, by members of the Committee on Education and the Workforce, initially found more than *760 Federal education programs.* After further evaluation, the committee found the total grew to 788 programs, spanning at least 39 Federal agencies, boards, and commissions, and costing roughly $100 billion a year.

# NATIONAL DEFENSE

## INTRODUCTION

Safeguarding the Nation's security is the first, and perhaps most important, duty of the Federal Government. If this security is threatened, other issues become secondary. Protecting this security requires effective and efficient operations at the Department of Defense [DOD]. As the Pentagon's *Annual Report to the President and Congress* (January 1994) put it: "Keeping U.S. military Forces fit to fight is the first priority of DOD. U.S. Forces must be manned, equipped, and trained to deal with the dangers to U.S. national security."

Wasteful spending saps the readiness of the Nation's Forces, weakening national security. The General Accounting Office [GAO], the Pentagon's own inspector general [IG], and other watchdog groups have found flagrant and continuing examples of waste, fraud, and abuse in DOD. These failures divert funds from vital defense programs.

But the Pentagon has not been able to account for the substantial amounts of money it spends. In the audit of its fiscal year 1997 financial statements, auditors could not determine on an overall basis if the statements for the Department of Defense were reliable. Since then, *DOD's financial accountability has grown worse*. According to the Department's inspector general [IG]: "This year, financial statements were more untimely than ever, and a record $1.7 trillion of unsupported adjustments were made in preparing the statements." (Department of Defense IG, *Semiannual Report to the Congress*, 31 March 1999)

GAO has designated the following four Pentagon activities as "high risk," reflecting an extraordinarily high amount of management shortfalls, flawed processes, and cost overruns. These areas are the focus of the discussion that follows:

< **Financial Management** – In addition to the accounting problems cited above, DOD is responsible for almost half of the Government's general plant, property, and equipment – but billions of dollars of its property valuation is unreliable.

< **Acquisition Problems** – The Department continues to suffer from longstanding acquisition problems, leading to costly errors in purchasing and inflated prices. The IG has described DOD's procurement practices as "poorly conceived" and "badly coordinated," and said the Department "has not yet learned how to be an astute buyer in the commercial marketplace."

- **Inventory Problems** – Inventory management problems have plagued the Pentagon for decades, and they continue creating large surpluses and shortages of inventory. At times, officials have been unable to locate equipment such as landing craft, aircraft engines, and missile launchers. Excess inventories also result in unnecessary storage costs.

- **Infrastructure** – The Armed Forces are top-heavy with uniformed supervisors, staff officers, chiefs, deputies, and directors – yet some services have continued asking for more top-level officers.

"At the core of the high-risk areas," GAO says, "is a fundamental lack of accountability. . . . High-risk areas involve long-standing problems that are difficult to correct." (GAO, *Major Management Challenges and Program Risks: Department of Defense*, January 1999)

But these are not mere accounting issues; they speak directly to the military's ability to carry out its mission of protecting the country. For instance, the U.S. Army recently rated two of its 10 divisions as unprepared for war, and *The Washington Post* characterized senior Pentagon officials as "stunned" by the news.

At the same time, however, DOD spends roughly $70,000 per troop annually on operations and maintenance ("readiness') costs – 30 percent more than it did a decade ago, even after adjusting for inflation. *The Wall Street Journal* summarizes the results of numerous Government studies as follows: "[T]he O&M [operation and maintenance] budget helps finance a system rife with inefficiencies: partly empty depots, underused testing facilities, commissaries that cannot compete with neighboring Wal-Marts and warehouses crammed with tens of billions of dollars in inventory that may never be used." (*The Washington Post*, 10 November 1999; *The Wall Street Journal*, 11 November 1999)

DOD is managed by three military departments, 24 Defense agencies, and several dozen subordinate organizations. It is the largest holder of Federal Government assets, at $1.3 trillion. In fiscal year 1999, the Department purchased about $135 billion in goods and services, using more than 250,000 contracts, grants, cooperative agreements, and other transactions. DOD also is the Nation's largest employer. The all-volunteer force includes 1.4 million persons on active duty, 705,000 civilians, and 1.35 million serving in the National Guard and Reserve. It also supports 1.8 million retirees and families who receive benefits.

## FINANCIAL MANAGEMENT

### Contract Overpayments

From 1994 through 1998, defense contractors returned a total of roughly $4.6 billion in overpayments from the Defense Finance and Accounting Service [DFAS] in Columbus, OH. Of that amount, $984 million was *voluntarily returned by the contractors themselves*. In many cases, says GAO, "the contractors, as opposed to DOD, were determining the existence and

amount of erroneous payments." (GAO, *DOD Contract Management: Greater Attention Needed to Identify and Recover Overpayments*, July 1999)

Says GAO: "DOD's reliance on contractors to identify these overpayments substantially increases the risk that it is incurring erroneous and unnecessary costs." GAO could not say how many contractors simply kept the overpayments that were undetected. (GAO, *DOD Procurement: Funds Returned by DOD Contractors*, October 1997)

### The Fox Running the Hen House

< **Stolen Funds** – An Air Force staff sergeant stole 17 checks, totaling $436,684, and attempted to steal two other checks worth $501,851. He used his job as chief of the data entry branch at the Defense Finance and Accounting Service [DFAS] at Dayton, OH, to falsify Government checks. He then had the checks mailed to his girlfriend and other associates. They, in turn, cashed the checks and sent the money back to the staff sergeant after skimming off a "commission." His alterations went unnoticed from 1996 to 1998 because of generally chaotic conditions at the DFAS center; the fraud only came to light after a coworker filed a sexual harassment complaint against the sergeant. (GAO, *Financial Management: Improvements Needed in Air Force Vendor Payment Systems and Controls*, September 1998)

< **Fake Billings** – The case above is similar to one in 1996, when an Air Force contracting specialist stole $504,000 at Bolling AFB by generating fake billings and opening a post office box for a fictitious corporation. *(Legi-Slate*, 8 July 1998; *Dayton Daily News*, 16 July 1998; GAO, *Financial Management: Improvements Needed in Air Force Vendor Payment Systems and Controls*, September 1998)

### Cooking the Books

"During the 1960s," says the Pentagon's inspector general, "DOD financial management was considered to be exemplary. Unfortunately, this has not been the case for quite some time." (Department of Defense IG *Semiannual Report to the Congress*, 30 September 1998)

Over time, the Department decentralized its management and developed thousands of automated systems that were not integrated with its financial and accounting systems. So roughly 10 years ago, the Department centralized these systems into the Defense Finance and Accounting Service [DFAS].

But this process created its own problems – the most serious result being that the Pentagon still *cannot reliably account for the money it spends.* This was demonstrated in audits by the Pentagon's IG of DOD's 1996, 1997, and 1998 financial statements. (Department of Defense IG, *Semiannual Report to the Congress*, 31 March 1999)

DOD is responsible for almost half of the Government's general plant, property, and equipment. Yet, billions of dollars of property valuation were unreliable. Examples:

< **Total of $7.8 Billion in Unsupported Inventory** – The Navy's financial statements omitted information on $7.8 billion in inventories aboard ships, increasing the risk that the Navy will order unneeded inventory. (GAO, *CFO Act Financial Audits: Programmatic and Budgetary Implications of Navy Financial Data Deficiencies*, March 1998)

< **Forty-Nine Buildings Valued at $0 or $1** – At one Navy location, auditors identified 49 buildings valued at a total of $25 million that were recorded at a zero or $1 value in the system used to generate the Navy's fiscal year 1997 financial statement. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

< **Fire Trucks, $1.03 Each** – The Air Force undervalued assets totaling $189 million because it priced its fire trucks at a unit cost of $1.03 rather than $470,000. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

If the Pentagon cannot put an accurate value on its property and equipment, DOD managers do not have the reliable information needed to make purchase decisions. This helps explain why the Pentagon has chronic problems with its inventory purchases. In addition, if the Department does not know the value of buildings that contain, for example, spare parts, it cannot tell what its inventory holding costs are – the true cost of its inventory. Also, it becomes difficult for DOD to compare its costs to the private sector when deciding whether to outsource or privatize an operation.

## ACQUISITION PROBLEMS

Two recent examples of the Pentagon's acquisition problems are the following:

< **Useless Trailers** – The Army spent $50.6 million for 6,700 two-wheeled trailers that now cannot be used unless the jeeps and trucks that pull them are modified. "Most of the 6,700 high-mobility trailers the Army has purchased are not usable because of a safety problem and not suitable because they damage the trucks towing them," according to the GAO. The Army plans to pay an additional $640 per trailer to correct the flaw. Not only did Army authorities fail to insist on a warranty that would make repairs for serious defects a responsibility of the contractor, but they still want to purchase 18,000 additional trailers. (GAO, *Defense Acquisitions: Army Purchased Truck Trailers That Cannot Be Used as Planned*, October 1999)

< **Defective Trucks** – The new medium trucks intended to haul the trailers also are defective. A GAO report says the following: "First, the Army chose a contractor that was not experienced in producing trucks. . . . The contractor had difficulty in both establishing a production line and producing trucks that could meet qualification and

operational testing requirements. Despite these problems, the Army allowed production to continue and increase during testing. As a result, many trucks were produced that required modification or repair [and] corrosion was discovered on the cabs of trucks. . . . Rather than making the contractor replace all 4,955 truck cabs . . . the Army relieved the contractor of a potential $21 million liability."

But the troubles did not end there. At highway speed, the driveshafts could vibrate and break, so the Army put a 30-mph limit on the trucks. (GAO, *Army Medium Trucks: Information on Delivery Delays and Corrosion Problems*, January 1999; "Your Money," ABC News, 5 February 1999)

Such examples reflect longstanding acquisition problems at the Pentagon. Testifying before the Senate Armed Services Committee, DOD's then-Inspector General Eleanor Hill said this about Pentagon purchases: "Department of Defense procurement approaches were poorly conceived, badly coordinated and did not result in the Government getting good value for the prices paid both for commercial and noncommercial items . . . we found considerable evidence that the Department of Defense has not yet learned how to be an astute buyer in the commercial marketplace." (Department of Defense IG, testimony to the Senate Armed Services Subcommittee on Acquisition and Technology, 18 March 1998)

DOD has the authority, on "commercially available" spare parts purchases, to avoid the overhead involved in negotiating a purchase price with the contractor, and simply buy the product at the listed catalogue price. This practice saves money on many contracts, but can lead to perverse results.

For example, some items, while listed as commercial, are not really commercial, so the price is not competitive; in other cases, the contractor merely inflates the catalogue price. DOD often exacerbates the situation by not holding out for better prices on quantity purchases. In March 1998, the Pentagon's IG released its audit of the program, and found the following:

< **Setscrews for $75.60 Each** – The Defense Logistics Agency [DLA] paid $75.60 each for 187 setscrews, a 13,163-percent increase over the previous price of 57 cents each. (Department of Defense IG, testimony to the Senate Armed Services Subcommittee on Acquisition and Technology, 18 March 1998)

< **Massive Price Hikes** – DLA paid $1.24 each for 31,108 springs, a 2,380-percent increase over the previous price of 5 cents each. DLA paid $5.41 each for 1,844 screw thread inserts, a 1,766-percent increase over the previous price of 29 cents. DLA also paid $403 each for 246 actuator sleeves priced earlier at $24.72. (Department of Defense IG, testimony to the Senate Armed Services Subcommittee on Acquisition and Technology, 18 March 1998)

< **A 280-Percent Markup** – In one contract, DLA paid $6.1 million for commercial parts that should have cost just $1.6 million under the Pentagon's "fair and reasonable" pricing standard, a 280-percent markup. (Department of Defense IG,

testimony to the Senate Armed Services Subcommittee on Acquisition and Technology, 18 March 1998)

A feature of buying from commercial parts catalogues is that it generally allows the buyer to eliminate inventory storage and distribution operations, and shift that burden to the vendor. The catalogue prices are supposed to reflect that burden. Yet in the case of the DLA orders, the buyer was buying for inventory and therefore the delivery went to a Government warehouse, not to a user of the parts. As a result, the Government paid premium prices for parts that ended up languishing in storage. (Department of Defense IG, testimony to the Senate Armed Services Subcommittee on Acquisition and Technology, 18 March 1998)

## INVENTORY PROBLEMS

Inventory management problems have plagued DOD for decades. DOD's antiquated inventory methods are costly and impede warfighting, as the Pentagon found in the wake of Operation Desert Storm. According to the fiscal year 1993 Federal Managers' Financial Integrity Act report: ". . . significant deficiencies in tracking inventory and maintaining inventory records . . . made operational support planning more difficult and were responsible for duplicate orders, backlogs at aerial and sea ports, unnecessary material shipped into the theater, difficulty in prioritizing cargo backlogs, and inefficient intratheater movement." (GAO, *Defense Logistics: Much of Inventory Exceeds Current Needs*, February 1997)

DOD's weak inventory management has led to both surpluses and shortages of parts. Some illustrative examples of inventory problems are the following:

< **Aircraft Parts** – The readiness of Air Force aircraft has declined from 80.8 percent mission capable in fiscal year 1993 to 74.3 percent in fiscal year 1998. What's more, the Air Force Chief of Staff has testified that mission-capable rates are expected to drop another 5 percent compared with fiscal year 1999. (Gen. Michael E. Ryan, Air Force Chief of Staff, testimony to the House Committee on Armed Services, 21 October 1999)

  GAO has found that in a majority of cases, the aircraft were grounded for lack of spare parts. But GAO has also discovered that the Air Force had a parts inventory worth $7.8 billion that both exceeded requirements and had no reported demand. In other words, the service had languishing in storage $7.8 billion worth of parts that may *never* be used, while at the same time a growing number of combat aircraft were unusable because of a lack of spare parts. (GAO, *Air Force Supply: Management Actions Create Spare Parts Shortages and Operational Problems*, April 1999; *Defense Inventory: Status of Inventory and Purchases and Their Relationship to Current Needs*, April 1999)

< **More Unneeded Parts** – A GAO audit of Air Force spare parts contracting showed that as of 30 September 1997, the Air Force had on order $384 million worth of parts that exceeded requirements. This included 64 turbine spacer assemblies at $1,200 each that were unneeded. But because the Air Force uses an inventory management system the GAO describes as flawed, the service decided not to terminate the contract. (GAO, *Defense Inventory: Improvements Needed to Prevent Excess Purchases by the Air Force*, November 1999)

**Excess Inventories**

About half of DOD's $65.8-billion inventory of spare and repair parts is not needed to support current operations or war requirements – and the Pentagon is continuing to buy excess quantities: as of September 1997, $1.5 billion of the $8 billion of inventory on order exceeded then-current operating and war reserve requirements. (GAO, *Defense Inventory: Status of Inventory Purchases and Their Relationship to Current Needs*, April 1999)

< **Circuit Card Assemblies** – In September 1995, the Navy had 27 circuit card assemblies for P-3 and S-3 aircraft (at $1,156 each) on hand, of which 25 were not needed. Yet the Navy ordered 10 more, which were delivered in May 1996. The item manager said that all the unneeded assemblies, including the newly delivered ones, were recommended for disposal. (GAO, *Defense Logistics: Much of Inventory Exceeds Current Needs*, February 1997)

< **Wave Oscillators** – In September 1995, the Air Force had 710 band-II backward wave oscillators (at $8,261 each) on hand. Although 682 oscillators, the vast majority of these items, were not needed, another 20 oscillators were on order. According to the item manager, the oscillators had been ordered because the manufacturer was shutting down production and the Air Force wanted to cover all requirements through the year 2040. (GAO, *Defense Logistics: Much of Inventory Exceeds Current Needs*, February 1997)

< **Direct Linear Valves** – In September 1995, the Navy had 67 direct linear valves, used in aircraft catapults, which cost $69 each. Fifty-nine valves were unneeded, but an additional 66 valves were on order. (GAO, *Defense Logistics: Much of Inventory Exceeds Current Needs*, February 1997)

**Storage Costs**

DOD also incurs significant overhead cost for housing spare and repair parts. Examples:

< **Bumpers** – "One $2.96 nonmetallic bumper that is used on the main gun of the Bradley fighting vehicle was the only item in a standard, small storage bin. The bin, which occupies 1.83 square feet of space, can hold 259 nonmetallic bumpers. Based

on the least expensive form of covered storage of $5.15 per square foot [note: this is what DLA actually charges the services for storage], *it costs the Army $9.42 a year to store the $2.96 item*." (GAO, *Defense Inventory: Spare and Repair Parts Inventory Costs Can Be Reduced*, January 1997)

< **Bolts** – "Two small bolts, unit price of $9.30, were being stored in a bin capable of holding 200 bolts. The bolt is also stored in two other locations, and the total on-hand quantity is 499 versus a current operating and war reserve requirement of 8." (GAO, *Defense Inventory: Spare and Repair Parts Inventory Costs Can Be Reduced*, January 1997)

Although the examples above involve minor individual expenses, the holding costs for more than 100,000 line items excess to requirements add up to $382 million annually. (GAO, *Defense Inventory: Spare and Repair Parts Inventory Costs Can Be Reduced*, January 1997)

**Lost and Found**

The Navy does not have a central system to provide worldwide visibility over military equipment. Instead, it relies on ad hoc reporting to determine what it has on hand. When GAO tested the system, it found some discouraging results:

< **Boats Sold** – Two of 45 active boats (landing craft and other small Navy vessels) tested were recorded as available for use, even though they had been sold. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

< **"Missing" Aircraft Engines** – Ten of 105 uninstalled aircraft engines were "lost" – because auditors were unable to verify their existence. These 10 engines were valued at up to $4 million each. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

< **"Missing" Service Craft** – Six of 79 service craft (auxiliary vessels for use in harbors and the like) were "lost." Value: up to $873,000 each. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

The Army has a central logistics system to provide worldwide visibility over equipment, but since 1993, GAO has reported long-standing problems:

< **"Missing" Missile Launcher** – The Army "lost" an Avenger missile launcher valued at $1 million. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

< **"Missing" Howitzer** – It also "lost" an M-119 howitzer, valued at $425,000. (GAO, *Department of Defense: Serious Financial Management Problems*, April 1998)

The Air Force maintains a central logistics system, but there were a number of problems in the data base. In one instance, more than 200 ground-launched cruise missiles were listed in the data base as actively assigned. They had been destroyed years ago as a result of an arms control treaty.

The Department of Defense, in its response to GAO's audit, said the items were not really "lost," and that subsequent investigation showed the Navy boats had already been sent for disposal, and the Avenger missile system was ultimately found (separate from its vehicle). But the ability to conduct modern, short-notice military operations hinges on the ability of DOD's logistics system to quickly, and accurately, locate equipment that may be needed.

## INFRASTRUCTURE

The Armed Forces have far more officers today, relative to enlisted personnel, than during World War II. Their structures are top-heavy with uniformed supervisors, staff officers, chiefs, deputies, and directors.

### More Officers for Fewer Troops

The U.S. Armed Forces won World War II with one officer for every 11 enlisted members. Today, there is one officer for every six enlisted members, though the Pentagon says troops are smarter and need less supervision than troops did 50 years ago.

< **Army** – For each of its divisions in World War II, the Army had 14 generals. Today, the peacetime Army has 30 generals, more than twice as many, for each of its divisions. Meanwhile, the basic combat units of the Army are seriously undermanned, with nearly every combat unit reporting severe shortages of riflemen. (Congressional Research Service, July 1998)

< **Navy** – During World War II, the Navy had 470 admirals directing 6,768 warships, or one admiral for every 14.4 ships. Today, the Navy musters 222 admirals for 354 ships, or one admiral for every 1.6 ships. (Congressional Research Service, July 1998)

< **Air Force** – In World War II, the Air Corps had one general for every 244 airplanes. Today, the Air Force has a general for every 23 airplanes. The Air Force and the other services have special offices just to keep track of their generals. The Air Force General Officers Matters Office is headed by a brigadier general. (Congressional Research Service, July 1998)

< **Marine Corps** – In World War II, the Corps had 79 generals for its six divisions. Currently, the Marines have 80 generals for just three divisions. (Congressional Research Service, July 1998)

### But They Still Want More

In 1997, the Pentagon asked Congress for 54 new slots for generals and admirals, to bring the total to 1,018, plus 32 more generals and admirals for the reserves. But a GAO report concluded the Department had not offered any convincing reasons for the additional brass, and the request was withdrawn. (GAO, *General and Flag Officers: Number Required Is Unclear Based on DOD's Draft Report*, June 1997)

< **A General Replacing a Colonel** – The Joint Chiefs of Staff hired a general to replace a colonel, a move that cost an additional $78,400 a year. The money covered the added cost or the general's salary, the salary of an executive officer for the general (the colonel he replaced didn't rate one), and the purchase of new office furniture, because the general merited better furniture than the colonel. (GAO, *General and Flag Officers: Number Required Is Unclear Based on DOD's Draft Report*, June 1997)

< **Twelve New Marine Generals** – Three years ago, the Marine Corps got 12 new generals. To accommodate them, the Marines had to fire six first lieutenants, five captains, and a major – officers who normally would rotate into combat leadership positions. (GAO, *General and Flag Officers: Number Required is Unclear Based on DOD's Draft Report*, June 1997)

**Other**

< **Continuation of Terminated Missile Research** – Although Congress explicitly terminated the Medium Altitude Air Defense system in 1998, DOD continued to spend more than $2 million on research and development, and actually announced the winner of a contract competition for the program. Congress also directed the Army to delay a multiyear contract for the previously cited trucks with corroded cabs and broken drivelines until the service developed a plan to identify and fix these problems. But the Army entered into a multiyear contract for the trucks anyway. (House Committee on Appropriations, *Report on the Department of Defense Appropriations Bill, 2000*, 20 July 1999)

< **Fly the Friendly Skies** – DOD's fleet of VIP aircraft (for which the Pentagon uses the euphemism "operational support aircraft") consists of 500 airplanes and 100 helicopters and costs $378 million annually for operation and support. DOD is supposed to maintain only as many aircraft as are required for executive transportation during wartime or similar crises, but fewer than half of DOD's VIP aircraft were used for this purpose during the Persian Gulf war. This fleet is larger than the number of combat aircraft in all but three air forces, and is larger than the combat aircraft fleets of France, Germany, or the United Kingdom. (GAO, *Government Aircraft: Observations on Travel by Senior Officials*, June 1995; Congressional Research Service, June 1998)

Even these figures, however, may understate the actual size of the Pentagon's VIP fleet. The 89th Military Airlift Wing (roughly 70 aircraft), based at Andrews AFB, is by Air Force regulation not considered an operational support aircraft unit. But most

of its duties consist of transporting Government executives. DOD officials commonly take helicopter flights between Andrews AFB and the Pentagon. These flights range from $400 to $1,600 compared to, say, $35 for cab fare (the Pentagon also has a huge motor pool).

Other examples of the Pentagon's questionable use of personnel or readiness funds include the following:

< **Home Improvement** – A sum of $14,000 was spent to convert the charcoal grill at the Air Force Academy's Otis House to natural gas, according to the Air Force Auditing Agency. Another $40,000 was designated for moving a bathroom wall at the house – the residence for the Commandant of Cadets – so that an adjoining bedroom's interior could be widened by 1 foot. In both cases, funding came from the Air Force's operations and maintenance account, which supports troop readiness. (Air Force Audit Agency, *Report on the Air Force Academy General Officer Quarters*, 26 October 1999)

< **Join the Navy, Be a Lunchroom Monitor** – Despite the difficulty in keeping experienced military personnel, the services continue to misuse servicemen and women in marginal or downright wasteful tasks. Aboard a Navy carrier, aviation maintenance specialists are assigned to manually count people in the chow line to see who prefers pork chops to hamburgers. Some passageways are repainted as often as every 2 weeks (commercial ships get by with once every 2 years). A RAND Corp. study says the 4,600-person crew of a carrier could be reduced by 1,500 sailors if sensible automation of "housekeeping" features were undertaken. But the first changes intended to reduce manpower on carriers won't appear till 2008. (*The Wall Street Journal*, 22 September 1999)

< **The 1st Public Relations Brigade (Mechanized)** – The Pentagon has 2,718 military and civilian personnel engaged in public affairs and congressional affairs activities. This is occurring at a time when the Air Force already has slashed its tactical air wings from 24 to 12, the Navy has reduced carriers from 15 to 11, and the Army has reduced its combat divisions from 18 to 10. The Defense Department's public relations cadre is about the size of an infantry brigade. (GAO memo to the House Committee on the Budget, 16 July 1998)

The GAO cautions that its preliminary estimate of public affairs personnel may be too low; previous audits of headquarters staff have revealed that the Pentagon routinely underreports the number of headquarters personnel. As one DOD official told GAO, the Pentagon likes to play a game of "hide the ball" with its headquarters staff. (GAO, *Defense Headquarters: Total Personnel Costs Are Significantly Higher Than Reported to Congress*, October 1997)

# HOUSING
# AND URBAN DEVELOPMENT

Since its creation in 1965, the Department of Housing and Urban Development [HUD] has spent $500 billion, supposedly to provide low-income people with decent, safe, and sanitary housing. But these funds have often bought the opposite of what was intended. Among the results have been the following:

< **Troubled Neighborhoods** – HUD's public and assisted housing projects have become nests of violent crime and drug trafficking.

< **Waste, Fraud, and Abuse** – Since 1994, the General Accounting Office [GAO] has termed HUD a "high-risk" agency – meaning it is exceptionally vulnerable to waste, fraud, and abuse. It is the only Cabinet-level agency to hold the designation. An example of the problem: HUD itself estimates that nearly $1 of every $18 it spends in its section 8 assisted housing program is wasted. HUD also has failed to provide timely and effective enforcement against those who defraud the system.

< **Deteriorating Housing** – While HUD's Federal Housing Administration [FHA] has sought to extend mortgage insurance to persons who cannot obtain home loans in the private market, it often has failed to assure properties are in good condition, or to provide needed financial counseling so buyers can keep up with their mortgage payments. Properties left abandoned after defaults are allowed to run down, or be taken over by drug dealers. This decay in turn infects surrounding neighborhoods.

< **Mismanagement** – HUD's own mismanagement is a major contributor to the problems listed above. HUD programs continue to proliferate while its shrinking staff remains poorly matched to program management and oversight. Furthermore, HUD's 3-year-old restructuring plan – a major undertaking known as HUD 2020 – *has made matters worse*, according to the Department's inspector general [IG].

HUD's own officials have acknowledged the severity of the Department's problems: "[Its] failings have made HUD the poster child for inept Government," says the executive summary of HUD's management reform plan.

The discussion below provides further background on these problems.

## TROUBLED NEIGHBORHOODS

In attempting to help the most needy with their housing needs, HUD has concentrated the poorest of the poor in vast public housing projects, where a culture of dependence has been created. Employment opportunities are limited, and often residents do not obtain the skills needed to fill what jobs are available. Crime is often the result.

Since 1994, crime and drug trafficking has been a priority for investigation by HUD's inspector general under the label Operation Safe Home. (The other areas investigated under this heading are fraud in the administration of public housing authorities, and equity skimming by owners of FHA-insured multifamily housing.) These problems, the IG says, "seriously undermine major HUD programs and they directly affect the quality of life of residents of HUD assisted housing." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

The IG's reports regularly contain numerous examples of crime and drug trafficking in HUD developments. A few recent examples are the following (additional examples appear in Appendix A at the end of this section):

< **Terrorized by Gang Members** – In Denver, 38 members of a gang called the Compton Crip Riders – known as the CC Riders – were arrested on organized crime, narcotics, and firearms charges. Curtis Park, a large public housing complex, had become an area terrorized and controlled by the gang since 1987. The CC Riders would invade a resident's apartments, funnel drugs into the complex, then move on to the next apartment when feeling police pressure. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Drugs, Weapons Seized** – In New Orleans, authorities arrested 109 persons around public housing and section 8 assisted housing projects, and seized more than 578 grams of marijuana, 540 grams of cocaine, 25 grams of heroin, $5,020 in cash, 10 weapons, ammunition, and drug paraphernalia. Most of those arrested were charged with drug and weapons violations or had outstanding fugitive warrants. It was part of an effort to control the "New Orleans 7th Ward Gang Soldiers," whose members have conducted what Federal authorities called a "reign of terror in and around public and assisted housing that has claimed several lives." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Drug Dealing Near School Grounds** – In Oakland, 131 persons were arrested in connection with drug dealing in and around FHA-insured apartments across from the junior high school attended by children from public and subsidized housing. Authorities also seized $17,900 in cash, more than 100 marijuana plants, more than 3 grams of tar heroin, 4 ounces of cocaine, small amounts of methamphetamine and rock cocaine, 500 grams of powder cocaine, three cell phones, two stolen credit cards, and drug packaging materials and paraphernalia. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Police Officers Shot At** – The situation at a Pittsburgh project-based section 8 apartment building became so serious that the property and the area adjoining it

produced the highest drug and violent crime statistics in the city, and police officers were being shot at while on routine patrol. The property manager refused to assist the police in evicting the problem tenants. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

Additional examples appear in Appendix A at the end of this section.

## WASTE, FRAUD, AND ABUSE

HUD will spend an estimated $31 billion in fiscal year 2000, well more than 10 percent of all annually appropriated spending on domestic programs. But as noted above, since 1994 GAO has considered the Department at "high risk" of waste, fraud, and abuse.

### Excess Subsidy Payments

In the section 8 assisted housing program, tenants pay rent up to 30 percent of their income; HUD makes up the difference. But HUD has limited ability to verify information on its assisted tenants and, hence, how much they ought to be contributing to their own rent and how much HUD should subsidize. When HUD matched tenants' reported incomes with IRS data, it found tenants vastly underreported their incomes. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1997 and September 1998)

One result: of the $18 billion that HUD spent in rent and operating subsidies in fiscal year 1998, "excess housing subsidy payments totaled $857 million," according to GAO. (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

This is nearly *twice* the overpayments estimated by the Department for 1995 when it identified $538 million in overpayments.

### Excess Rent Increases

HUD continues to pay higher rents than Department policy and law allow. The rents for 54 out of 1,219 HUD-subsidized projects were supposed to have been reduced to below 120 percent of fair market rents.

But HUD staff granted rent increases exceeding 150 percent of fair-market rent, costing the Department $17.4 million per year in excess rental payments. (Department of Housing and Urban Development IG, *Audit Report: Section 8 Rent Increases Under the Budget-Based Method*, 31 March 1998)

< **Rents More Than Five Times Market Value** – At two section 8 projects in Rhode

Island, rents were approved at rates exceeding 500 percent of the fair market rent for similar apartments. HUD raised the rents it paid to an amount necessary to fund the project owners' requests regardless of the fair market rent. (Department of Housing and Urban Development IG, *Audit Report: Section 8 Rent Increases Under the Budget-Based Method*, 31 March 1998)

< **Rents More Than Three Times Market Value** – On 1 January 1996, in Rhode Island, HUD increased the rents at one apartment complex to 311 percent of the fair market rent. Because this contract does not expire until 2004, the owners could realize up to $17.5 million over and above 120-percent-of-fair-market rent limit. (Department of Housing and Urban Development IG, *Audit Report: Section 8 Rent Increases Under the Budget-Based Method*, 31 March 1998)

## Widespread Abuses

HUD's poor contracting, and its lax controls and monitoring, have left the agency highly vulnerable to fraud and abuse. They also have allowed shoddy work, poor service, or outright theft. Even when such abuses are found, often they have been taking place for a long time; and even after discovery, remedial steps are not always taken quickly. Millions of dollars in subsidies have been stolen or misused every year, because HUD has consistently failed to prevent unethical persons from misusing them. Some recent examples:

< **"Ghost" Tenants** – In Chicago, a former section 8 manager for the North Chicago Housing Authority was indicted for misusing Federal funds. She invented fictitious "ghost" tenants and received $100 per month in subsidized rent for each one she created. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Hidden Ownership** – On Long Island, the chairman of the local housing authority used landlords to hide his ownership in a property rented to a section 8 resident. He continued to collect rent payments for *2 years* after the resident moved out, resulting in a $30,000 loss to HUD. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

As the inspector general has said: "Fraud and abuse in the administration of HUD's Public and Indian Housing Programs erode public support and detract from the scarce resources available to provide better living conditions for residents." Embezzlement, bribery, kickbacks, bidding irregularities, false claims, and conflicts of interest have all been found in HUD programs. (Department Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1997)

Examples include the following:

< **Luxury Homes by HUD** – In 1996, a $2.5-million HUD grant intended for

low-income housing was used to build luxury houses on big lots, including a 5,296-square-foot house for the executive director of the local public housing authority [PHA] and her husband, who made $92,319 a year. (Department Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1997)

< **Misspent HUD Funds** – After the public housing authority [PHA] in Camden, NJ, was given $1.65 million to reduce drug use in its housing project, drug arrests by the Camden police actually *increased* 32 percent between 1990 and 1994. The PHA also paid $6,200 in overtime to employees who were not eligible for it, and employees bought $33,239 worth of items unrelated to their official duties. (Department Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1997)

HUD loans also have been misused, as illustrated in the following examples:

< **Misused Development Loan** – On Long Island, NY, a HUD developer/former public official used the proceeds of a $250,000 development loan for his personal use instead of for the intended single family development. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1997)

< **Bogus Nonprofit** – A real estate agent in St. Louis, MO, created a fictitious nonprofit company known as the Catholic Mission. He then provided downpayments in the form of gift letters for the buyers of several properties. The agent obtained more than $250,000 in sales proceeds from these transactions. The loss to HUD was $40,000. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1997)

Additional examples of fraud and abuse appear in Appendix B at the end of this section.

### Lack of Enforcement

Several inspector general reports to Congress expressed concern about HUD's poor enforcement abilities. According to audits and other investigative reports, HUD was not penalizing those who defrauded HUD programs, and, generally, was not enforcing its regulations and contractual agreements.

Some examples reported by the IG include the following incidents:

< **Seven Years of Embezzling –** The partners and employees of a realty management firm in Brooklyn embezzled $10.8 million from multifamily projects. They took money from eight HUD-insured, low-income assisted housing developments for their own use and embezzled section 8 housing assistance paid by HUD to these developments. These events took place from 1990 through 1997, during which time the projects received $52 million from HUD. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **HUD Failed to Follow Through on Its Warnings –** In Connecticut, the owner of a HUD-insured project defaulted on the mortgage in 1995 and was still in control of the project (as of the time of the report). At the time of default, the owner was already under a 3-year HUD imposed debarment. Following default, HUD continuously advised the owner of potential enforcement actions HUD could take, but did not follow up on its warnings. The owner continued to withdraw project funds even after default. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1997)

< **Funds Redirected –** The Las Vegas Housing Authority continued to use federally assisted low-rent funds to support other nonassisted housing projects. This practice was first reported by the HUD IG in 1989. At that time, the Authority had misused more than $6 million. In 1992, the Authority continued to improperly use Federal funds, increasing amounts due to more than $6.5 million. Seven years later, in 1996, the IG found that the improper practices continued, increasing the ineligible expenditures to more than $7 million. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1996)

< **A Mortgage Ignored –** The management agent of four HUD-insured projects diverted more than $4.7 million while the mortgages were in default. The agent made no payments on the properties for the 4½ years he was the management agent. The properties, with mortgages totaling more than $19 million, were later foreclosed and sold, resulting in a $10-million loss to HUD. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1996)

## DETERIORATING PROPERTIES

HUD continues to allow properties it owns to deteriorate, which in turn does harm to surrounding neighborhoods.

### FHA Hurting Its Own Clients

The IG has continued to report that the Federal Housing Administration [FHA] cannot effectively detect when losses occur early enough, and prevent them from happening. "[The] FHA does not have adequate systems, processes, or resources to identify and effectively manage risks in its insured portfolios. What's more, the FHA can't monitor all its programs to effectively avoid fraud and abuse, and to minimize losses." (Department of Housing and Urban Development IG, testimony to the House Banking Subcommittee on Housing and Community Opportunity, 1 April 1998)

The FHA's worthy goal is to extend mortgage insurance to Americans unable to obtain home

loans in the private market. But the administration's own *HUD Reinvention* says: "Today's FHA is outdated, inefficient, and increasingly ill-equipped to prudently manage a Fortune 100-sized insurance company with a $380-billion portfolio of insurance-in-force backed by the U.S. taxpayer."

The FHA often fails to assure properties are in good condition, to provide financial counseling to buyers, or to help home buyers get back onto a regular schedule of payments if they default. After the FHA takes control of a defaulted property, the property often deteriorates during the long delay in selling it.

These results – which persist because the FHA, as currently structured, lacks incentives to prevent them – may infect the surrounding neighborhood with crime and drugs. This was explained in the following testimony:

> When you live in a neighborhood that has been destroyed by FHA lending it is sometimes hard to believe that the program was actually intended to help families and communities. The large number of FHA foreclosures in my neighborhood has meant an increasing number of families losing their homes and having their credit ruined for 7 years. It has meant abandoned HUD homes on block after block in my neighborhood. Homes that are taken over by drug dealers, homes that are not taken care of by HUD, homes that children are raped in and young people are killed in. (Testimony of Grace Jackson, Operational Chairperson of Roseland Neighborhood Housing Services of Chicago, to the House Committee on Banking and Financial Services, 2 April 1998)

GAO, in testimony related to a survey of FHA-owned properties, stated that in one area 39 percent of the properties were not locked – a situation that led to trespassing, vandalism, and property deterioration. Inspectors found properties with "broken windows, graffiti, and exposed walls in the bathrooms where valuable copper piping had been ripped out." In another area, 71 percent of the properties contained "imminent hazards, such as broken or rotting stairs." (GAO, testimony to the House Banking Subcommittee on Housing and Community Opportunity, 1 April 1998)

The inspector general notes that, as part of HUD's latest restructuring effort (see discussion below), FHA set goals for reducing the turnaround time on properties and increasing its return on appraised values. But FHA has fallen short of these goals. Says the IG:

> HUD's reorganization efforts adversely affected staffing and impacted its ability to adequately monitor the condition of program properties and enforce contractor compliance. Our review confirmed what FHA performance reports were showing: property inventories increasing, property conditions worsening, sales to homeowners declining, and average sales return compared to appraised value decreasing. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

### Failure of HUD's Title I Property Improvement Program

The program was intended to combat unemployment and help improve neglected properties. There are no specific income requirements for persons using the program. HUD's oversight of the Title I Home Improvement Program is minimal: it is focused on claim payments, with little attention paid to identifying or preventing program abuses by lenders or contractors. The Department has no system to track violations or otherwise determine if a pattern exists. Also, HUD's systems do not provide specifics as to who the program serves. Only through industry interviews and reviews of home mortgage disclosure information, required under the Home Mortgage Disclosure Act [HMDA], can HUD get any idea as to who the title I program serves. According to the inspector general, the HMDA data for 1995 suggest that only about 28 percent of the borrowers were at the low- and moderate-income level. (Department of Housing and Urban Development IG, testimony to the House Banking Subcommittee on Housing and Community Opportunity, 30 April 1998)

## MISMANAGEMENT

### Failures of the 2020 Reform

To a large degree, the problems described above can be linked to mismanagement in the Department. These have included a mismatch of programs and staff, a lack of oversight, and weaknesses in financial systems – all of which are discussed further below.

An embarrassing example appeared with the so-called "Creole" translation. According to accounts, HUD had contracted with the Government Printing Office [GPO] to translate a residents' brochure into nine languages. GPO subcontracted with a translator for the "Creole" version, which included passages such as this: "Yuh as a rezedent, ave di rights ahn di rispansabilities to elp mek yuh HUD-assisted owzing ah behta owme fi yuh ahn yuh fambily." A HUD public affairs officer later denounced the brochure – of which 2,000 were printed and 1,500 distributed – as bogus and offensive. But a HUD official signed off on a proof of the translation. (*StraightDope*, 8 November 1999)

According to the Department's IG, the most recent attempt to reform HUD has actually *worsened* its problems. In 1997, the Department undertook a major restructuring, called HUD 2020. According to the IG, however, the management reform "lacked an analytical basis." The IG went on to say the reform may have had a *detrimental* effect:

> The continual state of change brought about by 2020 has had a crippling effect on many of HUD's ongoing operations. In many respects, the Department has been operating on two tracks, one putting 2020 organizational systems in place and the other carrying out ongoing work. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

The IG added: "The new organizations called for by HUD 2020 have been established and staffed, but in most cases they are not fully operational and it remains unclear when they will

be fully operational or what their effect will be on HUD operations. In two cases, however – Community Builders and Management and Marketing Contracting – we have already seen negative effects." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Community Builders** – As part of HUD 2020, the Department redirected about 10 percent of staff resources to new "Community Builder" [CB] positions. The CB personnel were to promote HUD programs and help participants solve community problems. But HUD's IG found that "HUD could not document its need for 778 CB positions." The IG also found "selection irregularities in the hiring of many Community Builder positions, including the use of inappropriate Federal hiring authority and the misapplication of veterans preference in the ranking of applicants." (The VA-HUD appropriations bill for fiscal year 2000 limited HUD's ability to hire new CBs from outside the existing staff.) The CBs also were paid at high grades, increasing HUD's average employee salary and causing morale problems in other segments of the Department "because of obvious grade imbalances."

  The IG also found that HUD could not document what effect, if any, the new CBs were having. HUD could only detail how many meetings were convened or how many presentations were provided. In some cases, the IG found, their "limited knowledge of HUD programs and/or their poorly defined responsibilities caused CB staff to give inappropriate guidance to communities or improperly interfere with HUD matters outside of their authority." Finally, the IG interviewed 59 Community Builders, of whom 39 said they spent more than 50 percent of their time on public relations activities.

  The IG concluded that the CBs "activities do little to address HUD's mission and require scarce resources being directed away from areas that could help in addressing the many identified material weaknesses in HUD programs." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Management and Marketing** – On 29 March 1999, most of the responsibility for selling foreclosed properties at the FHA was contracted out to Management and Marketing [M&M] companies. Nationwide, the M&M work was given to 16 contractors and had a 5-year value of about $927 million. The inspector general found the contracts failed to contain "(i) sufficient information regarding FHA's reimbursement to contractors for property repair costs; or (ii) monetary penalties for contractor noncompliance." The new contract monitoring manual also provided no guidance in assessing the reimbursement of repair costs, the assessment of contract risk, and documenting results. All of these are needed to help make sure contractors are doing their job and to prevent abuse.

  The IG's concerns about placing the multibillion dollar workload in the hands of a few contractors were justified when HUD's largest contractor, which had received 45 percent of the workload, declared bankruptcy. The person who owned the contracting

firm was a felon who had declared bankruptcy numerous times before obtaining the $367-million contract. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

### Mismatch of Programs and Staff

Underlying the HUD 2020 failures are several longstanding management problems, including its proliferating programs and staff ill-suited to manage them.

One new program is the FHA Bridal Registry, in which newlyweds can have gifts deposited with their banks to go toward their house downpayments – something people could easily do before the program was created. Meanwhile, HUD lacks adequate staff personnel to properly oversee these proliferating programs. Despite widespread agreement that the HUD staff needed to be trimmed, the most recent reductions were not based on any clear objectives. According to the IG, since 1997 HUD staff has declined about 12 percent, to about 9,200 now – "a target level that lacked any analytical basis." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

For at least the past 5 years, the IG has said HUD does not tie workloads to staff resources, and that in many areas staff members cannot perform assigned duties. GAO says HUD suffers from "an insufficient mix of staff with the proper skills" which hampers "the effective monitoring and oversight of HUD's programs and the timely updating of procedures." (GAO, *Major Management Challenges and Program Risks: Department of Housing and Urban Development*, January 1999)

### Financial Systems Weaknesses

Every year, by law, HUD programs must undergo financial audits, which have highlighted serious and longstanding weaknesses. Despite repeated IG warnings, the Department has made limited progress in addressing these weaknesses. Problem areas include financial management systems, resource management, controls over subsidy payments, monitoring of program participants, and management control program. (Department of Housing and Urban Development IG, testimony to the Senate Banking Subcommittee on Housing Opportunity and Community Development, 7 May 1998)

More specifically, these problems include the following:

< **Unreliable Data Systems** – Serious data problems exist in such basic areas as funding levels, reserve levels, renewal information, and resident information. HUD has systems that are not compatible, so one computer database cannot communicate with another. The problems are a result of years of neglect. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Inflated Prices for Computers** – HUD purchased computer equipment and

accessories at prices far higher than the fair market rate. The Department paid as much as 20 percent more than market prices and 93 percent of the equipment was higher than the prices on the General Service Administration [GSA] price list. (Department of Housing and Urban Development IG report, 5 June 1998)

< **Obsolete Systems** – After spending $100 million on systems integration over the past 5 years, the Department still relies mainly on "legacy" systems – i.e., those already developed and now becoming obsolete – for financial management and program support. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1997)

Since these episodes, the Department has hired a chief procurement officer, established a contract management review board, and assigned trained representatives to oversee contracts. It also has sought to link procurement with core accounting systems. But the IG remains doubtful about the effectiveness of these efforts, saying: "[W]e are not convinced that the Department's overall contracting attitudes and practices have changed significantly from 2 years ago. Indeed, we found that many of the planned improvements appeared more substantial on paper than in reality." (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

## Appendix A
## ADDITIONAL EXAMPLES OF TROUBLED NEIGHBORHOODS

Additional examples of criminal activity in and around HUD properties and developments are described below.

[Please note: The inspector general organizes discussions of these incidents geographically. The listed below reflects that arrangement.]

< **Los Angeles** – Sixty individuals were arrested and 50 weapons – including a grenade – were seized at several public housing developments. Charges included murder, attempted murder, robbery, selling cocaine, assault with a deadly weapon, parole violations, possession of concealed firearms, burglary, being a felon in possession of a firearm, and grand theft auto. A large number of gangs were responsible for illegal drug activity and associated violence within these public housing developments, where the gangs were operating. In one operation, there were three Federal indictments charging 30 people – all alleged gang members – with responsibility for four murders, three attempted murders, 13 conspiracies to commit murder, two conspiracies to distribute controlled substances, a robbery, a robbery conspiracy, and an extortion conspiracy. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1999)

< **San Francisco** – Sixty-six gang members in or near the FHA-insured/HUD-subsidized Marcus Garvey/Martin Luther King complex and the Freedom West and Sunnydale HUD-subsidized developments were arrested. Authorities confiscated more than 605 grams of cocaine, 504 grams of marijuana, 2 ounces and a loaded syringe of heroin, 3 ounces of methamphetamine, $18,000 in cash, four cellular telephones, and various drug paraphernalia. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1999)

< **Rockford, IL** – Seventeen individuals were arrested and more than 600 grams of crack cocaine, 6 grams of marijuana, one weapon, and $6,477 in cash were seized at various public housing developments. In one operation, authorities arrested a mid-level narcotics dealer; in another, authorities executed a search warrant at a heroin supply house controlled by the Vice Lords gang and used to bag heroin for sale at the Concord Commons public housing development. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1999)

< **Washington, DC** – Two public housing developments are known as the largest open air heroin and crack cocaine markets operating in the city. A crackdown by authorities on one operation resulted in 37 arrests, 13 search warrants, and the seizure of $9,260 in cash, 237 grams of crack cocaine, 204 grams of heroin, and 140 grams of marijuana. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Florida** – Thirty-five people were arrested for the sale of drugs at a section 8 development. This was in addition to the 80 individuals previously arrested for the sale of drugs at the development. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **San Diego** – At a multifamily housing development, 51 stolen vehicles were seized in an undercover operation. Six people were arrested. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Chicago** – More than 70 percent of the drug sales of 70 pushers were found to have occurred within 1,000 feet of public housing complexes and a nearby school. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Gary, IN** – Three members of the Vice Lords street gang were apprehended, and later convicted, on various weapons and drug charges including distribution in and around the Delaney and Duneland public housing complexes. Within the housing complexes, two weapons were seized, along with a small quantity of cocaine. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **New Orleans** – Authorities arrested 323 individuals on various drug-related crimes – 145 from public housing developments and 178 from section 8 areas of the city. During these operations, authorities seized two weapons, six vehicles, more than 2,200 grams of marijuana, cocaine, crack cocaine, and heroin, one residence, and more than $37,600 in cash. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Omaha** – The Area Drug Task Force executed four search warrants after a 3-month probe that began in an auto repair shop and expanded to housing and storage units. The repair shop was being used to set up drug sales. One key distributor lived in a section 8 apartment complex. Eight persons were arrested and $35,000 in cash and drugs valued at more than $90,000 were seized. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Camden, NJ** – At the Westfield Acres and McGuire Gardens public housing developments, authorities arrested seven drug pushers and seized more than 500 bags of crack, nine bags of heroin, and three bags of marijuana. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Ironton, OH** – In and around the River Hills public housing complex, authorities arrested 25 individuals on various charges of drug possession and trafficking. In certain instances, food stamps were used to purchase drugs, including crack cocaine. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Philadelphia** – An undercover surveillance operation at a public housing development identified two persons as area drug distributers. The operation seized a kilo of cocaine, valued at $150,000. It was destined for area drug sellers and users located in and around the development. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Rhode Island** – Ten members of a gang that terrorized public housing developments were apprehended and convicted on charges including violations of the Racketeering Influenced Corrupt Organizations Act, conspiracy, murder, witness intimidation, firearms violations, and drug distribution. The 10 individuals were sentenced to a total of nine life sentences plus 120 years and 38 years plus 2 months in prison. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **South Carolina** – Authorities arrested 61 individuals at several section 8 properties and eight public housing complexes. In the process, the authorities confiscated 25 weapons, 462 grams of crack, 327 grams of marijuana, 3 grams of heroin, and more than $15,000 in cash. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Tennessee** – A husband and wife were identified as the major source of methamphetamine in two areas of the State. Most of the methamphetamine was sold in both public and assisted housing complexes. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Dallas** – Authorities arrested 105 individuals in a variety of public and assisted housing projects around the metropolitan area. The authorities also seized 20 weapons, more than $100,000 in cash, and drugs including crack, marijuana, and methamphetamine. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Fort Worth** – A public housing resident activist who started a children's assistance group was found to be a drug peddler. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

## Appendix B
## FURTHER EXAMPLES OF WASTE, FRAUD, AND ABUSE

Additional examples of waste, fraud, and abuse in HUD programs include the following:

< **Rhode Island** – In Charlestown, RI, an IG audit of the Narragansett Indian Wetuomuck Housing Authority's administration of its housing development grant disclosed that the Authority lacked the administrative capability to run a development program. It spent $3.2 million without developing any livable low-rent housing units. Even now, 10 years after HUD agreed to provide the development funding, the Authority still cannot proceed with the development, and cannot account for the funds it has used: the procurement process could not be fully documented for any contract; there was poor documentation on almost $900,000 of development costs; and significant budget overruns occurred without HUD approval. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Puerto Rico** – An audit of Community Development Block Grants [CDBGs] in Arecibo, PR, identified about $6.2 million of ineligible costs, $300,000 of unsupported costs, and an additional $300,000 in cost inefficiencies. In managing its block grants, the municipality failed to complete two major construction projects and allowed properties to deteriorate significantly. Since 1988, the municipality has spent about $5.3 million in program funds on these projects. In May 1997, it approved the sale of part of one of the properties for $250,000. In July, it advertised the remaining part for sale, although no value determination had been made. HUD had not approved either sale.

  Also, between fiscal years 1993 and 1997, the municipality improperly used about $768,000 in CDBG funds to pay employees who performed general government duties. About $237,000 was budgeted for similar employee services for the 1997-1998 fiscal year. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, September 1999)

< **Lake Havasu, CA** – A tribal chairwoman and her daughter, the former tribal secretary-treasurer, were convicted of conspiracy and embezzlement. They had embezzled $180,000 by charging personal expenses to tribal credit cards and cashing tribal checks. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Georgia** – Three employees of the Sylvester Housing Authority, including the former executive director and administrative assistant, were indicted for embezzling more than $55,000 from resident rent receipts. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Continued Abuse at Public Housing Authorities –** Despite years of reports, abuses at public housing authorities continue to be found, including the following examples from HUD's inspector general:

- The deputy executive director of the East Baton Rouge Housing Authority made more than 135 residents' money orders payable to herself rather than depositing them in the PHA's account. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- The chief of disbursements at the Baltimore City Housing Authority obtained more than 60 blank Housing Authority checks and issued them to herself or to a friend. They used the money – approximately $142,000 – to cover personal bills, entertainment, and other personal expenses, including drugs. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- The manager of a west Baltimore housing cooperative took $22,500 in bribes from prospective residents who did not want to wait on the waiting lists for subsidized apartments. The manager accepted bribes from at least 15 people and moved them up the waiting list. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- The executive director of the Montgomery Housing and Redevelopment Authority in Minnesota stole more than $14,000 in rental receipts from the Authority. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

< **Fraud by Federally Insured and Section 8 Project Operators** – HUD's poor oversight has allowed owners and operators of these projects to use the money that should be aiding low-income tenants for their own personal interests. Examples from the Department of Housing and Urban Development IG:

- The executive director of the Shawnee Housing Authority in Kansas concealed receipts of Authority funds by cashing checks and using the money himself. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- An employee of the Fairfax County Department of Housing and Community Development's Section 8 Program created fictitious owners and residents in the computer system and general ledger to embezzle over $77,000. The scheme was only uncovered when the supervisor found a ledger sheet on the floor and asked for the file on the resident receiving the subsidy. When the file could not be found, further reviews disclosed numerous other fictitious residents. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- The executive director of the St. Croix Chippewa Housing Authority in Wisconsin diverted more than $50,000 in public housing assistance funds by issuing checks to fictitious landlords, cashing the checks and converting them to money orders, and then using the money for her own benefit. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- In San Francisco, the on-site manager of Vicentaina Villa Apartments, used more than $72,000 in rent payments for personal expenses. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- The owners of the Redwood Villa multifamily project in Mountain View, CA, spent more than $330,000 on excessive compensation paid to two stockholders and a stockholder's wife for managing the project. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- In Indianapolis, the general partner of Woodbrook Associates was ordered to pay HUD more than $134,000 plus interest, attorney's fees, and costs related to litigation following a civil complaint filed in Federal district court. The partners instead used the money to pay friends, their own bankruptcy-related expenses, secretarial service expenses, and travel expenses. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

- A civil complaint filed against the sole general partner of a partnership that owned a property in Indianapolis operated as a nursing home sought more than $700,000 under the double damages provision of the equity skimming statute. The investigation disclosed that payments made to a lessee were not deposited into project funds as required under the regulatory agreement. Because the partnership failed to make mortgage payments, the project defaulted on the FHA-insured loan. (Department of Housing and Urban Development IG, *Semiannual Report to the Congress*, March 1998)

# MEDICARE

## INTRODUCTION

In the most recent semiannual report of her Department's inspector general, Health and Human Services Secretary Donna E. Shalala wrote: "Fraud, waste, and abuse threaten to undermine the effectiveness of [the Department's] programs, cost taxpayers billions in lost and wasted dollars, and deprive vulnerable beneficiaries of the care and support they need."

But in the Department's largest program – Medicare – waste, fraud, and abuse persist, coupled with longstanding, systemic problems in the way the program is run. The General Accounting Office [GAO] has retained Medicare on its list of "high-risk" programs, meaning it is exceptionally vulnerable to fraud and abuse. Some key problems:

< **Improper Payments** – Medicare's fee-for-service program made $12.6 billion in improper payments in fiscal year 1998, the most recent year analyzed. Although this appeared to be better than the previous year, the improvement was mainly the result of better paperwork, rather than changes in actual billing practices.

< **Fraud** – The improper payments quantified cannot account for any fraud the program suffers. Indeed, recent accounts show that Medicare has attracted its own class of organized criminals – persons who specialize in defrauding health care and health insurance systems.

< **Mismanagement** – Program administrators have failed to provide sufficient safeguards and oversight to assure Medicare funds are properly spent.

< **Flawed Payment Mechanisms** – Medicare grossly overpays for some services because of the nature of its own payment mechanisms – but the total amount of these excessive payments has not been quantified.

To paraphrase Secretary Shalala, wasteful and fraudulent spending drain away resources that are intended for legitimate Medicare beneficiaries, and threaten the credibility of the program. The following discussion further describes the four problem areas listed above.

Medicare covers about 39 million persons age 65 or older, and certain disabled persons. Enrollees may receive benefits through traditional fee-for-service, or the alternative of Medicare+Choice. Most enroll in fee-for-service, choosing their own providers for covered

services, while Medicare pays for the services. Those choosing Medicare+Choice also receive all covered services, as well as benefits that may not be available through fee-for service.

The program is administered by the Health Care Financing Administration [HCFA] in the Department of Health and Human Services [HHS].

## IMPROPER PAYMENTS

When the HHS inspector general [IG] administration reported $12.6 billion in improper Medicare payments for 1998, the otherwise disturbing figure suggested at least a trace of good news: it was $7.7 billion *lower* than the previous year. The results came from the IG's review of 5,540 Medicare claims (Medicare processes approximately 900 million claims each year) to find how many did not "comply with Medicare laws and regulations." The IG conducted similar audits of the program in 1996 and 1997.

But closer analysis reveals some qualifications to that reduction.

The IG's audits group major types of improper payments into essentially four categories (with a fifth characterized as "other" errors). The first category, concerning documentation, reflects Medicare regulations requiring providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. In cases in which this documentation is not provided, or is inadequate, the auditors consider the payments improper.

This category of improper payment declined from $10.8 billion in 1996, to $9 billion in 1997, to $2.1 billion in 1998 – simply because providers did a better job of furnishing these records.

The other three major categories of improper payments in the IG's audit include "a lack of medical necessity" for a payment, "incorrect coding" for a payment (the IG uses the term "upcoding" to characterize fraudulent practices), and payment for "noncovered or unallowable services." These kinds of improper payments totaled about 78 percent of the $12.6 billion of improper payments in fiscal year 1998.

The IG concluded: "[T]he Medicare Program remains inherently vulnerable to improper payments . . . payments relating to medically unnecessary services ($7 billion) and improperly coded services ($2.3 billion) are of significant concern." (Department of Health and Human Services IG, *Improper Fiscal Year 1998 Medicare Fee-for-Service Payments*, February 1999)

## FRAUD

One reason Medicare fraud is so difficult to quantify is the elusive nature of the practice. Says Harvard Prof. Malcolm K. Sparrow, an expert in health insurance fraud: "There's a trap of circularity – you look for what you've seen before. Meanwhile other kinds of fraud are

developing within the system that remain invisible because you're not familiar with them and you have no detection apparatus for that. . . . It's like in Hollywood movies, trying to blow smoke on the invisible man. For a moment you see what's there – but only for a moment." (Interview with the *AARP Bulletin*, October 1997)

Professor Sparrow added that systems used by Medicare (as well as private insurers) are not really designed to detect fraud. "They [these systems] could never be expected to detect fraud because that's not really what they are set up to do. They are all aimed at billing correctness, utilization review, policy coverage." (Interview with the *AARP Bulletin*, October 1997)

**A New Criminal Class**

Among the most troubling developments in Medicare fraud is the emergence of an organized class of criminals who specialize in defrauding these systems. According to the General Accounting Office [GAO]: "While the full extent of the problem remains unknown, we did determine that career criminal and organized criminal groups are involved in Medicare, Medicaid, and private insurance health care fraud or alleged fraud throughout the country. . . . Criminals previously involved in other types of crime are now migrating into the health care fraud arena." (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

From its review of seven cases of health care fraud – four involving Medicare and Medicaid – GAO found the following about the criminal groups that had infiltrated the system:

> These groups created as many as 160 sham medical entities – such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment [DME] companies, often using fictitious names or the names of others on paperwork – or used the names of uninvolved legitimate providers to bill for services and equipment not provided or not medically necessary. For the most part, these entities existed only on paper. Once the structure was in place, subjects used a variety of schemes to submit claims to Medicare, Medicaid, or private insurance companies. (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

Among the practices employed by these groups, and applied to Medicare, are the following:

< **"Mail Drop"** – Perpetrators rented private mailboxes or drop boxes, set up bogus corporations, and opened phony corporate bank accounts. They then billed Medicare for services or equipment that were never provided, using beneficiary and provider information they had stolen or purchased. Checks were received in the drop boxes, and then deposited in the controlled bank accounts, then converted to cash or moved to other bank accounts where authorities could not reach them. The practices continued even after some of the subjects were arrested, indicted, or jailed. (GAO memorandum,

*Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

< **"Patient Brokering"** – In this scheme, also known as "rent-a-patient," subjects sent out recruiters (also known as "runners"), who invited "patients" to clinics owned or operated by the subjects for unnecessary tests of medical services. The clinic operators paid a fee to the recruiters, who in turn paid a portion of their fee to cooperating "patients." (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

< **Gaining Physician Cooperation** – Medical school graduates and/or physician assistants performed the actual procedures, which included noninvasive medical tests and filling out medical charts. Licensed physicians were then paid $50 to $100 per medical chart to sign records for services they had neither performed nor supervised, or to provide referrals that were not needed. (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

Disturbingly, GAO also said: "Because of the multiplicity of schemes and the ease with which subjects move their operations from location to location, law enforcement officials find it difficult to keep up with this growing and widespread form of fraud and are often unable to seize or recoup fraudulent proceeds that are quickly moved out of their reach." (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

**Other Forms of Fraud**

Apart from this organized criminal activity, Medicare continues to be subject to more "traditional" kinds of fraud, such as the following:

< **Massive Dialysis Scam** – A national chain of kidney dialysis centers agreed to pay $486 million to settle allegations that, over a period of years, its officials caused Medicare to pay for hundreds of thousands of needless tests for patients with renal disease – a condition that often requires kidney dialysis. In addition, the company allegedly paid kickbacks to obtain referrals of lab business which is a violation of antikickback statutes. It was the largest health care fraud settlement in the Justice Department's history. (*The Washington Post*, 19 January 2000)

< **Physician** – In California, a physician submitted claims for persons who had died before the date of claimed services, persons living in other States, persons who were incarcerated, and the like. The physician had previously pled guilty to charges of

Medicare fraud related to submitting false claims for house calls. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Physician** – A Michigan podiatrist billed Medicare for incision and drainage of wounds and abscesses when he only performed noncovered routine nail care. In addition, he prescribed Tylenol No. 3 to patients although some of them had not even removed their shoes for examination. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Fraudulent Use of Names and Numbers** – In Florida, the owner of a DME company was sentenced for conspiracy to defraud Medicare via mail fraud. In order to generate claims for his company, he paid beneficiaries for the use of their names and Medicare numbers. He also paid cash to physicians for their signatures on oxygen-related DME prescriptions and to a company owner for false oxygen testing results. (Department of Health and Human Services IG, *Semiannual Report*, September 1999.)

More examples of such fraudulent practices appear in Appendix C at the end of this section.

### Fraudulent Processing Contractors

When a Medicare provider – for example, a doctor or hospital – submits a bill to Medicare, the bill is sent not to the Government, but to one of 64 claims processing contractors. The contractors handle about 900 million Medicare claims each year for roughly 1 million hospitals, physicians, and medical equipment suppliers. Medicare contractors use Federal funds to pay health care providers and are reimbursed for administrative costs. Some of these contractors commit outright fraud. In recent congressional testimony, GAO revealed a variety of contractor activities that reflected fraud. According to GAO:

> [A]t least eight Medicare contractors have been convicted of criminal offenses, have been fined, or have entered into civil settlements since 1993. Admitted or alleged improper activities included, but were not limited to, improperly screening, processing, and paying Medicare claims; destroying claims; and failing to properly collect money owed to Medicare by providers. In addition, contractors falsified their performance results and engaged in activities designed to deceive HCFA and circumvent its review of contractor performance. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

GAO focused on three contractors to provide examples of criminal and other improper activities that contractors allegedly or admittedly engaged in to deceive HCFA. These examples included the following:

< **Improperly Screening, Processing, and Paying of Medicare Claims** – According to an investigating agent, a contractor – in an effort to receive the maximum payment by maximizing the number of claims processed – rushed claims through the processing system and shut off computer edits designed to catch problem claims. A whistleblower

reported that the contractor also paid claims without proper physician signatures or backup documentation. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **Improperly Destroying or Deleting Claims** – To eliminate backlogs of unprocessed claims, a contractor allegedly deleted some claims that contained incomplete or incorrect information by using special computer coding. Claimants were not notified that these claims would not be paid, and were not told what information was needed to correctly process their claims and given an opportunity to provide it. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **Failure to Collect Medicare Overpayments and Interest** – A contractor settled a suit involving allegations that it circumvented a requirement to collect provider overpayments within 30 days of the overpayment determination date by making it appear that payments were collected on time when, in fact, they were not. As a result, the contractor allegedly did not assess interest on the overpayment, as is required. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **Falsifying Documentation and Reports Regarding Performance** – A contractor falsified reports to HCFA on which performance evaluations were based, to make its performance appear better than it was. These reports included information about claims processing errors, claims processing timeliness, and timely contractor response to incoming customer telephone calls. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **Altering or Hiding Files** – A contractor altered or hid files that involved incorrectly processed or paid claims, and inadequately performed contractor audits of Medicare providers prior to HCFA's review of the files. Methods used to alter files included: first, stamping "signature on file" on claims that had been paid without a signature; second, detaching documents to give a false appearance; and third, altering procedure codes to make it appear that claims had been paid properly when they had not. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

### Contractors' Ineffectiveness

Even honest contractors are not always effective in detecting Medicare fraud. Contractors are supposed to undertake a number of safeguards, which include using special fraud units to investigate potential cases. But their effectiveness is uneven. Says the IG:

> [E]ffectiveness varies considerably and often performance is not directly related to the size of the unit or the total amount of resources allocated. Total caseloads

> among the fraud units varied from 0 to over 600 . . . In reviewing carrier case files, we also found that some allegations of fraud were being lost during the overpayment adjustment process and were not properly developed as potential fraud cases. (Department of Health and Human Service IG, *Areas of Concern – 2000*, 7 December 1999)

One reason for this variation may be that the contractors themselves – regardless of how responsible they might be – have no direct financial incentive to detect fraud in the system. In this regard, Professor Sparrow has written the following:

> The vice president for audit for one major Medicare contractor explained carefully how all their various types of audit did something other than measure the fraud problem. External audit examined the procedures of external business affiliates. Internal audit focused on separation of functions, system security, and opportunities for employee corruption. Quality review processes were all aimed at procedural adherence. None of these procedures was designed to detect fraud attacks by claimants, or to measure the level of fraud in the system.
>
> Faced with this glaring omission (which left the contractor with no idea whether their fraud problems were any worse or better than anyone else's) and asked whether his company might consider instituting a program of random audits for systematic measurement, the vice president for audit commented: "There is no reward for finding fraud. There are no out-of-pocket losses for us [as a Medicare contractor]. Why would we put ourselves in this painful position?" (Sparrow, *License to Steal: Why Fraud Plagues America's Health Care System*, 1996)

In any case, once a case *is* developed for referral to the IG, resolution of the case can be difficult. If satisfied the evidence warrants prosecution, the IG forwards the case to the Department of Justice. A U.S. attorney then decides whether to prosecute the case. Although the mechanics for pursuing Medicare fraud are in place, the resources and interagency coordination required for case development can delay the resolution of a case for years.

## HCFA MISMANAGEMENT

Compounding the problem is the Government's own laxity in monitoring and oversight of Medicare payments. Says GAO: "The lack of sufficient oversight and monitoring controls can lead to improper payments by fostering an atmosphere that invites fraud." (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

Congress has sought to improve the situation legislatively, through provisions of the Health Insurance Portability and Accountability Act of 1996 [HIPAA] and the Balanced Budget Act of 1997 [BBA]. But GAO says: "Although legislation has been enacted . . . to bolster the Health Care Financing Administration's oversight capability, initiatives to curb fraud, waste, abuse, and mismanagement have been slow to develop." (GAO report, *Major Management Challenges and Program Risks: Department of Health and Human Services*, January 1999)

The Health Care Financing Administration [HCFA] grants broad discretion to contractors in implementing safeguard activities, resulting in significant variations from one contractor to the next. But HCFA has failed to provide sufficient oversight and monitoring. Says GAO:

> The lack of sufficient oversight and monitoring controls can lead to improper payments by fostering an atmosphere that invites fraud. For instance, both we and the HHS IG have reported that HCFA's insufficient oversight of the Medicare Program hampered it from preventing improper payments . . . [V]ulnerabilities in contractors' procedures for paying Medicare claims have provided a lax environment. This environment permitted unscrupulous providers opportunities to obtain unjustified payments. These activities include billing for services never rendered, misrepresenting the nature of services provided, duplicate billing, and providing services that were not medically necessary. (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

In the three cases of fraudulent contractors described above, HCFA had failed to detect improprieties – because HCFA notified contractors in advance that it would be making oversight visits and reviewing records. According to GAO, HCFA's current oversight process could allow the same kinds of improper contractor activities to continue undetected elsewhere. This mismanagement takes the following forms:

< **HCFA Seldom Validates Contractors' Internal Controls or Workload Data** – Medicare contractors are required to certify that they have a system of internal management controls over all aspects of their operations. But HCFA accepts Medicare contractors' self-certification of management controls without routinely checking that the controls are working as intended. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **HCFA Sets Few Performance Standards for Contractors** – According to GAO, HCFA's contractor performance evaluation [CPE] is "more descriptive than evaluative." There are only a few mandated standards, and no standards require HCFA reviewers to ensure that contractors adequately perform the most important safeguards – such as medical review of claims. There are few performance standards to motivate contractors, and no benchmarks for HCFA to use in holding contractors accountable. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **HCFA Regions Provide Uneven and Inconsistent Reviews and Remedies** – Contractor oversight is highly variable across regions, with limited guidance from regional headquarters and little followup to ensure the guidance that does exist is followed. In the absence of common performance standards and expectations, there exists uneven review of critical program safeguards and inconsistencies in how HCFA reviewers handle contractor performance problems. Uneven review continues to leave HCFA unable to discriminate among contractors' performance. GAO does concede, however, that HCFA has recognized its oversight of contractors has been inadequate

and issued guidance last year to have regional reviewers follow a somewhat more structured evaluation process. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

< **HCFA Lacks a Structure That Assures Accountability** – GAO highlights two particular problems with HCFA's organizational structure and its effect on oversight accountability. First, in 1997, HCFA dispersed responsibility for contractor activities from one headquarters component to seven. Second, HCFA's 10 regional offices – ostensibly the front line for overseeing contractors – do not have a direct reporting relationship to headquarters units responsible for contractor performance; instead, they report to the HCFA Administrator. GAO believes this dispersed responsibility for contractor activities and regional office reporting relationships contribute to communications problems with contractors and exacerbate the weaknesses of HCFA's oversight process. (GAO, testimony to the House Commerce Subcommittee on Oversight and Investigations, 9 September 1999)

GAO also has highlighted other areas of HCFA mismanagement, including the following:

< **HCFA's Lack of Coordination With Contractors** – As noted above, contractors have broad discretion in conducting Medicare antifraud-and-abuse activities, resulting in significant variations in implementing these activities. Part B contractors establish their own medical policies and screens, which are the criteria used to identify claims that may not be eligible for payment. Certain policies, and the screens used to enforce them, have helped some Medicare contractors avoid making improper payments. But HCFA has failed adequately to coordinate contractors' use of these policies and screens, according to GAO. (GAO letter to the chairman of the House Committee on the Budget, *Medicare: Fraud and Abuse Control Pose a Continuing Challenge*, 15 July 1998)

< **HCFA's Financial Oversight Problems** – In its audit for fiscal year 1998, the IG was unable to give an unqualified opinion on HCFA's financial statements, in large part because the contractors lacked sufficient documentation to support the "receivable" amounts reported. (Medicare accounts receivable primarily represent funds that medical care providers owe to HCFA due to overpayments, as well as funds due from other entities in instances in which Medicare is the secondary payer of claims.) The IG found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors it reviewed. Some contractors were unable to provide documentation to support their beginning balances; others reported incorrect activity, including collections; and still others were unable to reconcile their reported ending balances to subsidiary records. For instance, two contractors had unreconciled differences in their reported ending balances of $44.7 million and $11.9 million, respectively.

The IG also found security for contractor and HCFA information systems has remained inadequate. For fiscal year 1998, HCFA relied on data processing operations at the contractors to process and account for Medicare fee-for-service payments. The

IG's review found electronic data processing control weaknesses at 11 of 12 contractors sampled. For example, the IG was able to penetrate the security systems and obtain access to sensitive Medicare data. Moreover, the IG found contractors were able to deactivate or bypass edits, such as those used to detect duplicate claims. (Department of Health and Human Services IG, *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998*, February 1999)

< **HCFA's Lack of Success With the Medicare Transaction System** – HCFA's efforts to develop on-line claims processing for contractors – the Medicare Transaction System [MTS] – have been unsuccessful. Without such a system, contractors cannot screen for suspiciously large reimbursement increases over a short period, or improbable quantities of services claimed for a single day of care. For example, in 1992, a contractor paid a supplier $211,900 for surgical dressing claims and then, for the same quarter a year later, the contractor paid the same supplier more than $6 million. Medicare had no system in place for identifying the 2,800-percent increase in the amount claimed beforehand. Until 1997, HCFA was attempting to develop the Medicare Transaction System to replace its existing Medicare claims processing systems. But the project was halted because of design problems and cost overruns. (GAO letter to the chairman of the House Committee on the Budget, *Medicare: Fraud and Abuse Control Pose a Continuing Challenge*, 15 July 1998)

## FLAWED PAYMENT MECHANISMS

In addition to problems with fraud and abuse in Medicare, the system suffers from fundamentally flawed payment mechanisms. Two areas in which this is evident are the Durable Medical Equipment [DME] payment system and Medicare's allowances for prescription drugs. The total losses from this problem are unknown and are separate from the $12.6 billion of improper payments in Medicare's fee-for-service program. Although the President's fiscal year 2000 budget proposed payment reductions in these areas, it did not resolve the underlying problems described below. (The President proposed limiting payments for orthotics and prosthetics to the national median, and limiting payments for outpatient drugs to 83 percent of the average wholesale price.)

### Durable Medical Equipment

In 1998, Medicare Part B paid $3.5 billion for medical equipment, supplies, prosthetics, and orthotics – products referred to as durable medical equipment [DME]. Although GAO has stated Medicare grossly overpays for some products, the amount of overpayment in the DME payment system is unknown.

There are two underlying problems with DME's payment system: first, HCFA does not know specifically what products Medicare is paying for; and second, the fee schedule allowance for

DME is out of line with current prices. (See further discussion of the fee schedule system below.) The following are examples of overpayments or flawed payment mechanisms in the DME payment system.

< **Claims Do Not Adequately Identify Products Billed to Medicare** – GAO determined, for example, that one Medicare billing code is used for more than 200 different urological catheters. The wholesale prices of these catheters range from about $1 to about $18. But GAO found that, among some suppliers, the catheters they most frequently provide are also the least expensive – about $1. Nevertheless, the Medicare fee schedule allowance for all the catheters in this group is about $11. (GAO, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, May 1998)

< **Medicare Fees Are Often Out of Line With Current Prices** – For example, in 1996 the average retail price for an intermittent urinary catheter with straight tip was 87 cents, while Medicare's floor and ceiling for each item were $1.43 and $1.68, respectively. (GAO, *Medicare: Need To Overhaul Costly Payment System for Medical Equipment and Supplies*, May 1998)

< **Medicare Fees Do Not Reflect Volume Discounts Obtained by Large Suppliers** – One large nursing home supplier billed Medicare for 78,100 bedside drainage bags in a 12-month period. The supplier's weighted average cost was about $2.24 per bag, but Medicare's fee schedule allowance was between $7.65 and $9.00. (GAO, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, May 1998)

### Problems Underlying Medicare's DME Payment System

Medicare Part B pays for most medical equipment and supplies using a fee schedule system. The fee schedules specify a Medicare allowance for each of about 1,900 groups of products, and each product group is identified by a code in the HCFA common procedure coding system [HCPCS].

All the products grouped under an HCPCS code having the same fee schedule allowance are intended to be similar items. When suppliers bill Medicare, they use the HCPCS code they believe best describes the product provided to the patient.

But some of the key problems in this system are the following:

< **HCFA Does Not Know Specifically What Medicare Is Paying for When Its Contractors Process Claims for DME** – Because Medicare pays the same fee for all the products billed under the same HCPCS code, suppliers have a financial incentive to provide patients the least costly product covered by the code. Suppliers can bill Medicare the full fee schedule allowance regardless of the product provided. (GAO,

*Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, May 1998)

< **The DME Fee Schedule Is Out of Line With Current Market Prices** – Most Medicare fees are based on historical supplier charges that are updated using the consumer price index [CPI]. HCFA and its contractors do not have sufficient, current product and pricing data for the thousands of DME items covered by Medicare. Additionally, the fee schedule allowances are the same for individuals and for large institutional suppliers, even though large suppliers buy at substantial discounts. (GAO, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, May 1998)

## Prescription Drugs

According to a November 1998 IG report, *Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs*, HCFA overpays for prescription drugs covered by Medicare. Medicare does not pay for over-the-counter or most outpatient prescription drugs. But under specific circumstances, Medicare Part B covers drugs used with DME or infusion devices. Medicare also covers drugs used in association with organ transplants, dialysis, chemotherapy, and pain management for cancer treatment. In addition, Medicare covers certain vaccines, such as those for influenza and hepatitis B.

Medicare allowances for prescription drugs totaled almost $2.3 billion in 1996. In 1997 – the most recent year for which complete figures are available – allowances rose to approximately $2.75 billion. After comparing the median Medicare allowance with the corresponding median Department of Veterans Affairs [VA] acquisition cost for 34 drugs, *the IG estimated that Medicare and its beneficiaries could have saved $1.03 billion in 1998 if the Medicare-allowed amounts for 34 drugs were equal to prices obtained by the VA under the Federal Supply Schedule* (see further explanation in Appendix D). The estimated savings represented almost half of the $2.07 billion in reimbursement that Medicare and its beneficiaries paid for these 34 drugs in 1997. Moreover, Medicare allowed between 15 percent and 1,600 percent more than the VA paid for the 34 drugs reviewed.

According to the IG: "We recognize that HCFA and the VA operate under different statutory constraints. Nevertheless, the fact remains that another Federal agency can get prescription drugs for a drastically lower price than Medicare." (Department of Health and Human Services IG, *Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs*, November 1998)

It is estimated that, if HCFA paid what the VA paid, Medicare could have saved $276 million for Leuprolide acetate (a cancer drug); $120 million for Albuterol sulfate (used to dilate the bronchia); and $61 million on Goserelin acetate (a cancer drug).

## Appendix C

## ADDITIONAL EXAMPLES OF FRAUD AND ABUSE

[Please note: The inspector general classifies abuses according to the kinds of providers involved. The listing below reflects this classification.]

### Services Not Rendered

As the category indicates, cases involving billing for services not rendered occur when health care providers bill Medicare for services they never provided. Fraud is usually detected by statements received from the providers' patients or their custodians and the lack of supporting documents in the medical records.

< **Physician** – A Virginia physician was sentenced for defrauding the Medicare (and Medicaid) Programs. He had practiced psychiatry for 30 years. He falsely claimed that he treated patients who actually were treated by a licensed professional counselor. He also improperly billed for treatment of his patients during hospitalization; for example, he submitted claims to Medicare for individual psychotherapy services and psychiatric evaluations not rendered. (Department of Health and Human Services IG, *Semiannual Report*, September 1999.)

< **Durable Medical Equipment Provider** – A man was sentenced in Florida for conspiracy to submit false claims in connection with his two durable medical equipment [DME] companies and his medical diagnostic company. From 1992 to 1996, the company owner paid patient recruiters to bring Medicare beneficiaries to certain licensed physicians whom he paid to order DME and diagnostic testing. Through his companies, he then submitted Medicare claims for DME and certain tests that were not rendered or were medically unnecessary. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Durable Medical Equipment Provider** – In Vermont, a DME supplier engaged in a telemarketing scheme whereby Medicare beneficiaries were contacted by telephone and were solicited to accept DME products. The company then billed Medicare for body jackets, flotation mattresses, and foam cushions that the beneficiaries never used or that were medically unnecessary. As a result, the company was overpaid approximately $400,000. The supplier agreed to pay to resolve civil liability for submitting false Medicare claims. (Department of Health and Human Services IG, *Semiannual Report*, September 1998)

< **Clinic** – In Florida, 12 persons were indicted for defrauding Medicare of more than $6 million between 1993 and 1996. In their scheme – which also involved physicians, patient recruiters, and unlicensed physicians' assistants – Medicare was billed for services that were not medically necessary or were not performed, and the proceeds were laundered by the clinic owners and employees. Of four persons sentenced in the case, two were owners/operators of six clinics and diagnostic companies; the other two

were clinic employees. (Department of Health and Human Services IG, *Semiannual Report*, September 1998)

< **Physician** – A psychologist diagnosed people with post-traumatic stress disorder as a result of auto accidents that never happened. She then billed Medicare, the Department of Labor, and various insurance companies for services not performed. Some beneficiaries received money for their part in the scheme. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Durable Medical Equipment Provider** – A North Carolina man established numerous fictitious supply companies supposedly doing business in the Charlotte, NC, area. He and other persons used the firms to bill Medicare for more than $13 million for nonexistent supplies, of which more than $2 million was approved. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

### Noncovered or Unallowable Service

Medicare publishes coverage rules on what goods and services the program will pay for and under what circumstances it will pay or not pay for certain goods and services. Providers sometimes bill Medicare, showing a billing code for a covered item or service when, in fact, a noncovered item or service was provided.

< **Home Health Agency** – A Texas home health agency and its owners reached a settlement with the Government for improper submission of Medicare claims. Investigation confirmed that the improper billings were for submitting home aide service claims without the required physician authorization. The owners were unable to obtain signed physician orders because the beneficiaries were not homebound. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Physician** – A Pennsylvania osteopath filed claims for chelation therapy, which is not covered by Medicare except in limited circumstances, and then billed for certain components that *are* covered, such as venipuncture, saline intravenous, and intravenous therapy. He paid to settle a civil liability suit. (Department of Health and Human Services IG, *Semiannual Report*, September 1997)

< **Physician** – An Iowa podiatrist paid to resolve civil liability for submitting improper Medicare claims. Between 1993 and 1995, an Iowa podiatrist billed for whirlpool treatments each time a patient visited his office. He also billed for removal of skin lesions when in fact he was performing noncovered routine foot care. He paid to resolve a civil liability suit for improper Medicare claims. (Department of Health and Human Services IG, *Semiannual Report*, March 1997)

### Lack of Medical Necessity

Medicare patients can be subjected to medically unnecessary procedures that are in many cases painful and dangerous. These procedures are performed for the sole purpose of profit to the physician or health care entity, at Government expense. Medically unnecessary services often are combined with kickbacks or services not rendered.

< **Hospital** – A California corporation agreed to resolve its civil and administrative liability for submitting Medicare claims for unnecessary services. The main subjects in the case were two hospitals owned by the corporation. Allegations included the payment of kickbacks to physicians at one of the hospitals for patient referrals, and the submission of false Medicare claims, resulting in improper payments to "management companies" involving psychiatric programs at the other hospitals. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Physician** – In Florida, a medical company and two of its subsidiaries signed a settlement agreement in response to allegations that it submitted false Medicare claims. The company formerly provided behavioral health services to long term care recipients through group practices in 12 States. Its licensed clinical social workers, psychologists, and psychiatrists rendered individual and group psychotherapy services to Medicare beneficiaries in Florida nursing homes over a 2-year period. During that time, the company allegedly submitted false claims to Medicare for medically unnecessary individual and group psychotherapy services. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Home Health Agency** – An IG audit of a Florida Home Health Agency [HHA] estimated at least $2.2 million of the $9.1 million claimed by the HHA did not meet Medicare payment requirements. The IG found the HHA's monitoring of its own employees and subcontractors was inadequate to ensure claims submitted were for services that met Medicare payment requirements. The largest portion of these unallowable services were provided to beneficiaries who were not homebound. According to the beneficiaries and others, these beneficiaries could leave home without considerable effort. (Department of Health and Human Services IG, *Review of Costs Claimed by Medicare Home Health Services Inc.*, April 1999)

< **Home Health Agency** – An HHA was paid for 25 skilled nursing visits totaling $1,198. Although documentation from the HHA indicated that the beneficiary was homebound, an interview with the beneficiary determined that she continued to drive an automobile and was not homebound. As a result, she was not entitled to Medicare coverage of home health services. (Department of Health and Human Services IG, *Improper Fiscal Year 1998 Medicare Fee-for-Service Payments*, February 1999.)

< **Hospital** – Investigation at a Florida psychiatric hospital showed that, over a period of 6 years, the hospital routinely admitted elderly patients for inpatient services that were not medically necessary. Many of the patients suffered from organic brain disorders and would not have benefitted from psychiatric treatments. In addition, the hospital provided inadequate patient care and falsified patients' medical records. The hospital

agreed to pay a fine to resolve its civil liability for fraudulent Medicare billings. (Department of Health and Human Services IG, *Semiannual Report*, September 1998)

< **Physician** – The physician-owner of a New Jersey laboratory performed various noninvasive tests on large groups of Medicare beneficiaries living in senior citizens apartment complexes. He billed Medicare for tests that were medically unnecessary and were not ordered by the patients' attending physicians. He agreed to pay the Government for submitting false claims. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Physician** – In Florida, a laboratory owner and a clinic owner were sentenced for Medicare fraud. Together with a cardiologist who contributed his signature and provider number, they defrauded Medicare of approximately $4 million over a 3-year period by billing for lab tests and medical treatment that were either never performed or were medically unnecessary. (Department of Health and Human Services IG, *Semiannual Report*, September 1997)

< **Hospital** – A hospital in Delaware agreed to pay to settle allegations of billing Medicare for unbundled services, "upcoding" (billing for a higher reimbursement than the service warranted), billing for services not documented, and billing for unnecessary services. Investigation showed that the hospital's billing lacked proper controls and was in disarray. (Department of Health and Human Services IG, *Semiannual Report*, September 1997)

< **Home Health Agency** – An HHA was paid $1,484 for home health and skilled services. The medical files contained no information showing that the beneficiary was unable to leave the home without assistance. After reviewing the Medicare homebound criteria, the prescribing physician stated that the beneficiary was not homebound. (Department of Health and Human Services IG, *Inspector General's Report on the Health Care Financing Administration's Financial Statements for Fiscal Year 1997*, 24 April 1998)

< **Hospital** – While operating an outpatient clinic for nursing home patients, an Ohio hospital submitted false claims for geriatric psychiatric services that were nontherapeutic or unnecessary. Many of the patients suffered organic brain disorders and would not have benefitted from psychiatric treatments. The hospital was overpaid more than $600,000 by Medicare and Medicaid. The hospital agreed to pay a settlement for defrauding the Medicare and Medicaid Programs. (Department of Health and Human Services IG, *Semiannual Report*, September 1996)

< **Physician** – One of Oregon's highest Medicare-billing ophthalmologists submitted false claims for medically unnecessary cataract surgeries. Several of the patients had near-perfect vision before surgery. The ophthalmologist gave the hospital false information about patients' visual acuities to justify the surgery. (Department of Health and Human Services IG, *Semiannual Report*, September 1996)

## Incorrect Coding

One type of incorrect coding is called "upcoding." Upcoding cases result from health care providers changing codes on claim forms submitted to Medicare, causing reimbursements to be paid at higher rates than are warranted by the service provided. Upcoding also can result from providers billing for services actually provided by nonphysicians, which would be paid at a lower reimbursement rate.

< **Physician** – After operating a furniture store in Miami for 20 years, two Florida brothers decided to open a clinic. Within a few months, they found they were not making enough money and elected, along with three physician employees, to bill for more expensive tests on all patients. More than 4,100 false claims were submitted to Medicare. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Physician** – A dermatologist billed and overcharged Medicare for the destruction of numerous skin lesions when patients were provided either weight loss or minor dermatological services. (Department of Health and Human Services IG, *Semiannual Report*, September 1996)

< **Physician** – An Ohio osteopath submitted claims for medical services that were either billed at a false higher rate or billed at a rate higher than that charged non-Medicare patients. (Department of Health and Human Services IG, *Semiannual Report*, September 1995)

## Kickbacks

Medicare is governed by an anti-kickback statute penalizing anyone who knowingly and willfully solicits, receives, offers, or pays – in cash or in kind – for: one, referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare program; or two, purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service, or item payable under the Medicare or Medicaid programs.

"Kickbacks" include bribes or rebates, whether direct or indirect. Common examples of kickback transactions include joint ventures designed to disguise illegal payments as profit distributions or dividends; "directorships" in exchange for high-volume patient referrals; "loans" that are subsequently forgiven; and provision of space either free or leased at less than market value.

< **Durable Medical Equipment Provider** – A DME company owner was sentenced for filing false Medicare claims, paying kickbacks, and money laundering. The owner paid

physicians kickbacks in return for patient referrals and certificates of medical necessity [CMNs] for equipment. The owner not only made cash payments to doctors, but also purchased items such as computers, jewelry, and Rolex watches to conceal his kickbacks. In one instance, he even fabricated the purchase of a medical practice. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Durable Medical Equipment Provider** – A New York podiatrist accepted kickbacks from a DME supplier for referring Medicare patients for medically unnecessary lymphedema pumps. While the podiatrist was on prepayment review, he hired podiatrists to work at his office and paid them a salary. He then billed Medicare for podiatry services using the other podiatrists' provider numbers. In addition, he solicited several privately insured individuals to permit him to bill their insurance carriers in return for a percentage of the reimbursement checks, and in some instances, for prescriptions for controlled substances. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Durable Medical Equipment Provider** – In Florida, a DME company received kickbacks as inducement to permit another DME supplier to provide incontinence kits to Medicare beneficiaries. These beneficiaries lived in a chain of nursing homes owned by the same management as the DME company. (Department of Health and Human Services IG, *Semiannual Report*, March 1999.)

< **Physician** – The owner of a mobile diagnostic laboratory paid kickbacks not only to impotence clinic owners, but also to numerous physicians in the area for Medicare patient referrals. Another subject of the case, the owner of a diagnostics service in Florida, was sentenced for paying kickbacks for Medicare patient referrals by clinic owners. The kickbacks were disguised as rental or marketing fees paid to the clinics. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Physician** – In Pennsylvania, five individuals participated in a scheme in which Medicare and Medicaid were defrauded. A physician, later sentenced to 121 months in prison, accepted kickbacks from a DME company for signing fictitious certificates of medical necessity. The DME company owner and two employees were sentenced earlier for fabricating test results and forging physician signatures as well. The physician's pharmacist brother also was sentenced for routinely billing Medicaid for brand name drugs while supplying generic brands. (Department of Health and Human Services IG, *Semiannual Report*, March 1996)

< **Durable Medical Equipment Provider** – Two brothers visited senior citizen high rises and conducted health fairs at which they coaxed beneficiaries into giving them their Medicare numbers. They furnished these numbers, along with forged CMNs, to two DME companies. The companies then billed for equipment, much of which was never supplied, causing Medicare to pay more than $750,000. The brothers were paid "commissions" depending on the cost of each piece of equipment. (Department of Health and Human Services IG, *Semiannual Report*, March 1996)

< **Durable Medical Equipment Provider** – The owner of record of a New York DME company fraudulently billed Medicare $2.36 million over an 18-month period. The company participated in a fraud scheme that in total cost Medicare more than $6 million. The scheme involved at least four doctors, eight salespersons and three company principals who engaged in false statements, kickbacks, and conspiracy by billing Medicare for reimbursable items such as hospital beds and wheelchairs which beneficiaries never received. (Department of Health and Human Services IG, *Semiannual Report*, September 1995)

## Appendix D
## COMPARISONS BETWEEN MEDICARE AND THE VA FOR PRESCRIPTION DRUG PAYMENTS

Some of the differences between the Medicare and VA payment systems for prescription drugs are the following:

< **Medicare's HCPCS Codes Do Not Specifically Identify the Drug Product Billed** – HCFA and its carriers identify drug products using codes in HCFA's common procedure coding system [HCPCS]. The HCPCS codes define the type of drug and, in most cases, a dosage amount. The codes do not identify the specific drug product billed. The VA, by contrast, uses National Drug Codes [NDCs] rather than HCPCS codes to identify drugs products. Each drug manufactured or distributed in the United States has a unique NDC. The NDCs identify the manufacturer of the drug, the product dosage form, and the package size. (Department of Health and Human Services IG, *Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs*, November 1998)

< **HCFA's Method of Reimbursement Is Out of Line With Current Market Prices** – Medicare reimburses doctors and suppliers for drugs that they administer or supply to beneficiaries. It reimburses covered drugs at 95 percent of the drugs' average wholesale prices [AWPs]. HCFA contracts with local carriers and four DME regional carriers [DMERCs] to process Part B claims and establish the Medicare-allowed amounts for covered drugs. These carriers determine the allowed amount for a drug based on the AWPs as reported in pricing publications used by the pharmaceutical industry.

The IG has found that actual wholesale prices available to physicians and suppliers are often significantly lower than the Medicare-allowed amounts. The IG believes there is evidence that the published AWPs used in determining the Medicare allowed amounts for certain prescription drugs can be many times greater than the actual acquisition costs available in the marketplace.

On the other hand, VA purchases drugs for its health care system directly from manufacturers or wholesalers. There are several purchase options available to the VA, including the Federal Supply Schedule. The Federal Supply Schedule provides agencies such as the VA with a simple process for purchasing commonly used products in various quantities while still obtaining the discounts associated with volume buying. Using competitive procedures, the Federal Supply Schedule awards contracts to companies to provide services and supplies over a given time. Agencies are not required to use the Federal Supply Schedule, however, and are able to negotiate prices lower than the schedule price. (Department of Health and Human Services IG, *Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs*, November 1998)

# MEDICAID

## INTRODUCTION

As noted in the previous section, Medicaid – along with Medicare and private health insurance – has been victimized by a special class of criminals who target these systems. In reporting on this criminal activity, the General Accounting Office [GAO] included this description:

> In some cases, beneficiaries have been known to provide only their insurance (i.e., Medicaid) number in exchange for cash. A laboratory would later bill their insurance for blood tests it conducted using someone else's blood. Also, clinic owners would send blood samples to labs to conduct tests and bill Medicare or Medicaid, and the labs would "kick back" some of the money to the clinic owners. An official from the New Jersey State Attorney General's Office, Medicaid Fraud Section, stated, "Most [beneficiaries] know that their Medicaid card is better than a VISA card for getting money." In essence, under this scheme, beneficiary and/or identifying information is "rented" or "brokered" to subjects. (GAO memorandum, *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers*, 5 October 1999)

Another form of fraud is that of bogus medical suppliers, who obtain provider numbers and begin billing Medicaid. In one of the most dramatic examples of this practice, recently disclosed, California's Medicaid program, called Medi-Cal, was defrauded of amounts that may exceed $1 billion – one of the largest frauds against a State in American history (see further discussion below).

Yet according to GAO, the Government has not even tried to determine the amount of improper payments – through fraud or other problems – occurring in the Medicaid Program, which is estimated to spend about $115 billion in Federal dollars in fiscal year 2000. GAO has said: "The Health Care Financing Administration [HCFA] – the HHS [Department of Health and Human Services] agency responsible for overseeing the Medicaid Program – has no comprehensive quality assurance program or other methodology in place for estimating improper Medicaid payments." (GAO, *Financial Management: Increased Attention Needed to Prevent Improper Payments*, October 1999)

Medicaid is the Nation's major public financing program for medical and long-term care services for low-income people. The Federal/State program – in which States share in the total costs – will provide coverage for 43 million poor people in 2000, including the disabled,

elderly, poor and near poor children, and pregnant women. Reports of the Department of Health and Human Services [HHS] inspector general [IG] provide evidence that provider fraud is increasing the cost, both to the Federal Government and to the States, of providing these Medicaid services.

Because States are required to match Federal funds, they have a financial incentive to monitor and control Medicaid spending. Almost all States (except Idaho, Nebraska, and North Dakota) have Medicaid fraud control units.

Still, as demonstrated in GAO's report on criminal activity surrounding both public and private health insurance programs, Medicaid remains highly vulnerable to fraud. Moreover, HCFA's inspector general has urged the agency to develop a method, in cooperation with the States, for measuring the extent of improper payments.

The persistence of wasteful and fraudulent spending costs Medicaid resources intended to reach legitimate beneficiaries, and weakens the program's credibility. Yet episodes of waste, fraud, and abuse continue to occur in Medicaid. Some examples are listed below.

**EXAMPLES OF FRAUD AND ABUSE**

< **State Defrauded of an Estimated $1 Billion** – In November 1999, Federal investigators announced that losses to the California Medicaid program (called Medi-Cal) may surpass $1 billion, one of the largest frauds against a State in American history. A joint Federal and State task force investigated the program after the number of medical supply stores skyrocketed, and payments for supplies jumped almost 50 percent between 1996 and 1998, from $173.4 million to $258.4 million. Charges have been filed against 64 businesses and their owners, 35 of whom have pled guilty and have been fined or are serving sentences ranging from 10 months to 3 years. An additional 300 businesses are currently under investigation.

According to accounts of the episode, loose regulations of the Medi-Cal program have made it relatively easy for fraud rings to operate. The scam operations obtain Medi-Cal provider numbers, then start billing electronically for nonexistent supplies and services. A 1 December 1999 editorial in *The Los Angeles Times* said: "The deception was so easy. Rent some office space. Put in a few shelves with a smattering of goods – some crutches and canes and a bedpan or two. Nail up a medical supply store shingle. Meet State standards so lax that only primary suppliers were expected to maintain records. Start billing the State Medi-Cal system for all sorts of fake sales and business and then just sit back and watch the checks come in." Investigators were tipped off by the proliferation of medical supply stores, and then " . . . simply follow[ed] the money." (*The Los Angeles Times*, 29 November 1999, and 1 December 1999)

< **Billing for Hospital Psychiatric Services Not Provided** – A Florida hospital chain paid $469,000 to settle allegations that between 1995 and 1997 it had billed for adolescent psychiatric services that were not delivered or not provided in accordance with Medicaid requirements. (Department of Health and Human Services IG, *Semiannual Report*, March 1999)

< **Overcharging for Home Health Services** – Between January 1994 and November 1997, a New York home health agency submitted tens of thousands of inflated bills to Medicaid for home health care services. Medicaid was charged as much as 25 percent above rates charged to privately insured patients, resulting in Medicaid overpayments of $600,000. In March 1999, the owner of the agency pleaded guilty to grand larceny. (National Association of Attorneys General, *Medicaid Fraud Report*, March 1999)

< **Charging for Medical Services Not Delivered** – Between February and August 1996, a Miami-based medical clinic defrauded Florida's Medicaid program of more than $1 million. The clinic submitted fraudulent medical claims for nerve conduction tests, allergy tests, and chemotherapy injections that had not been provided. (National Association of Attorneys General, *Medicaid Fraud Report*, February 1999)

< **Fraud Lawsuit for Speech Pathology Services** – In February 1999, the Missouri Attorney General filed suit against a speech pathologist saying that more than $205,000 in false claims had been obtained from the Missouri Medicaid program over a 16-month period (September 1997 through January 1999). The lawsuit charges that the services for which claims were filed were never performed or, in some cases, the actual services performed should have been reimbursed at a much lower rate. In many instances the speech pathologist submitted claims for services in excess of 24 hours in a single day. As part of a prejudgment attachment, the sheriff's department took possession of a 1999 BMW Z3, a 1998 Jaguar, two late-model pickup trucks and three all-terrain vehicles, among other items. (National Association of Attorneys General, *Medicaid Fraud Report*, February 1999)

< **Kickbacks in Massachusetts** – According to a December 1998 indictment, from 1992 through 1997, a Massachusetts psychiatrist took kickbacks totaling nearly $600,000 annually in connection with his two psychiatric businesses. Allegedly, the psychiatrist would repeatedly prescribe medically unnecessary tranquilizers, such as Valium, to known substance abusers. To receive the drugs, the patients had to undergo multiple sessions of testing by psychologists who allegedly paid the indicted psychiatrist up to $3,000 a month in "rent." Medicaid paid the psychologists between $500 and $600 for each of these testing sessions, totaling nearly $1.8 million over the 5-year period in which the violations took place. (National Association of Attorneys General, *Medicaid Fraud Report*, December 1998)

< **Fraudulent Billing for Vision Services** – Between July 1995 and April 1998, a Philadelphia vision center billed Medicaid for vision services not delivered, according to a criminal complaint. Medicaid allegedly was defrauded of $140,000. Employees of

the vision center told agents that the center owner trained them to add extra services to the bills submitted to Medicaid. (National Association of Attorneys General, *Medicaid Fraud Report*, October 1998)

< **Pharmacy Overbilling** – Between 1989 and 1998, two pharmacies in Hawaii overbilled the Medicaid program by more than $226,000. The pharmacies billed for expensive name brand drugs when the less expensive generic drugs should have been dispensed and billed. (National Association of Attorneys General, *Medicaid Fraud Report*, September 1998)

< **More Pharmacy Overbilling** – Between January 1994 and January 1998, the Massachusetts Medicaid Program was overcharged by more than 600 pharmacies. These pharmacies were dispensing partially filled prescriptions to customers when they lacked sufficient stocks of drugs. After delivering the partial prescriptions, the pharmacies would allegedly tell the customers to come back for the remainder of the prescriptions the following day. In many instances, the recipients of the medication would not return, but the pharmacies' automatic computer billing system continued to charge the Medicaid program the cost of full prescriptions. (National Association of Attorneys General, *Medicaid Fraud Report*, June 1998)

< **Overpayment of Laboratory Services** – Over a 2-year period, in a review of 22 States, the HHS inspector general concluded that States potentially overpaid laboratory providers by an estimated $33.9 million ($19.4 million Federal share) for various laboratory tests because States did not have adequate controls to detect and prevent inappropriate payments. Contrary to applicable laws and guidelines, States paid medical providers more for clinical laboratory services processed by physicians' offices, independent laboratories, and hospital laboratories for outpatients than the amounts Medicare recognizes for the same services. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **The Chiropractor Scam** – Between 1996 and 1998, a group of chiropractors in Indiana received more than $4 million as a result of suspected fraudulent billing. Investigators concluded that the chiropractors billed for services not rendered and for services that were unnecessary, and offered money to Medicaid recipients to bring other Medicaid recipients to their offices for services. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Overcharging for Prescription Drugs** – In July 1998, a Georgia hospital agreed to pay $4.3 million to settle allegations that it overcharged the State Medicaid program for prescription drugs over a 10-year period. The suit alleged that the hospital submitted two claims for each prescription. (BNA Newsletter, 11 July 1998)

< **Not by the Book** – A Massachusetts orthopedic surgeon collected more than $100,000 for dozens of unnecessary x rays and injections given to 19 patients, thereby committing Medicaid fraud. Ironically, the treatments contradicted advice given in a

book the doctor had written. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Expensive Day Care** – In April 1998, NBC News' "Fleecing of America" series reported that a Federal grand jury had indicted a Georgia doctor for billing Medicaid for counseling service not provided. According to the report, the doctor was out of the country on some of the days he billed taxpayers for services. Hundreds of Atlanta children were bused daily to several of his centers for an after-school day care. But over a 14-month period, he billed Medicaid more than $6 million for medical therapy services for the children. Government investigators and former employees said all that was provided was day care. According to the Georgia Department of Medical Services commissioner: "He billed for services that weren't provided to people who had no medical necessity." (NBC News, April 1998)

< **Alleged Kickbacks for Unnecessary Tests** – According to a September 1997 indictment, between January 1995 and June 1996, United Diagnostic Laboratory billed the New Jersey Medicaid program approximately $5 million for expensive and unnecessary blood tests. The indictment contends that the company paid $1.7 million to the owners of five medical clinics to refer blood samples to the United Diagnostic Laboratory for tests. (National Association of Attorneys General *Medicaid Fraud Report*, September 1997)

< **Overcharging for Home Health Services** – Between 1994 and 1997, U.S. Home Care, which provides personal care aides to the sick and indigent in New York, Connecticut, and Pennsylvania, submitted thousands of inflated bills to Medicaid covering 1.2 million hours of service. This resulted in a $1.75 million settlement in April 1998. The company incorrectly charged Medicaid a higher rate than it charged non-Medicaid patients, in violation of State regulations. (National Association of Attorneys General, *Medicaid Fraud Report*, April 1998)

< **Questionable Charges by Group Home Operator** – Between 1990 and 1994, an Ohio man and his corporation, which operated four group homes for the mentally retarded, charged Medicaid more than $490,000 for, among other things, hiring a go-go dancer as a consultant and installing a sound system for a go-go nightclub. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

< **Repeat Offender** – Between 1993 and 1995, a DC taxi driver defrauded the District of Columbia Medicaid program of $31,890 by obtaining blank taxicab vouchers from health care facilities and submitting completed vouchers for inter-State destinations. The inspector general for HHS had investigated and prosecuted the taxi driver earlier for working the same scheme. (Department of Health and Human Services IG, *Semiannual Report*, March 1998)

# FOOD STAMPS
# AND OTHER NUTRITION PROGRAMS

## THE FOOD STAMP PROGRAM

As noted in the introduction, the Food Stamp Program made an estimated $1.4 billion in improper payments in 1998, according to financial statements from the Department of Agriculture [USDA]. The figure reflects *a problem that has been growing worse*. According to the Congressional Budget Office [CBO], the rate of food stamp overpayments rose from 6.9 percent in 1996, to 7.3 percent in 1997, to 7.6 percent in 1998. The General Accounting Office [GAO] has often noted these longstanding problems, as in the following account:

> Millions of dollars in overpayments in the Food Stamp Program occur because eligible persons are paid too much or because ineligible individuals improperly participated in the Food Stamp Program. For example, thousands of prisoners and deceased individuals have been included as members of households receiving food stamps. (GAO, *Major Management Challenges and Program Risks: Department of Agriculture*, January 1999)

The Food Stamp Program is intended to provide low-income households with coupons or electronic benefits that they can use like cash to buy food at Government-approved grocery stores or mobile vendors. The vendors take the food stamps to their banks, who credit the vendors' accounts and receive reimbursement from the Government. Food stamp benefits reach about 9 million households, or 22 million individuals, daily. The program, operated through the Department of Agriculture's Food and Nutrition Service [FNS], is estimated to spend $19 billion in fiscal year 2000.

The discussion below describes the program's systemic weaknesses, and provides examples of ways in which food stamps are abused.

### How Food Stamps Are Abused

Because food stamps are a kind of parallel currency, they are subject to fraud and misuse by beneficiaries, vendors, or others who may handle them.

< Some recipients exchange their food stamp benefits for ineligible products such as cigarettes.

- Some recipients trade food stamps for cash to buy items such as clothing, toys, or other consumer goods.

- Illegally used food stamps obtained by vendors can be "trafficked" among a variety of businesses, who exchange the stamps at increasingly higher values until an approved vendor redeems them.

- Because food stamp eligibility is based on income, some people misrepresent their economic status to qualify for benefits. The practice may range from simply failing to disclose income to misrepresenting the size and composition of a household.

These problems entail more than a loss of taxpayers' money; they also waste funds intended to help low-income families buy food. GAO has given the following explanation of how the design and management of the program themselves contribute to its problems:

> [I]mproper payments frequently occur because agency personnel lack needed information, rely on inaccurate data, and/or do not have timely information. . . . For example . . . interstate duplicate participation in the Food Stamp Program goes undetected because there is no national system to identify participation in more than one State. While States may currently learn of some duplicate participation . . . they rely primarily on applicants and clients to truthfully identify who resides in their households. . . . Because USDA's most current annual estimate indicates that food stamp overissuances account for over 7 percent of the program's $20 billion in annual benefit expenses, it is critical that action be taken to strengthen systems and related controls. (GAO, *Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

**Examples of Abuse**

Some examples of abuses – compiled from recent reports by the USDA's inspector general [IG], the General Accounting Office [GAO], and other sources – appear below.

- **Food Stamp Benefits Given to Persons Disqualified From the Program** – More than 3,000 persons in four States collected more than $500,000 in food stamp benefits – even though they had been disqualified because of fraud or other misconduct. The misallocation occurred either because the States did not remove disqualified beneficiaries from the rolls on a timely basis, or because they failed to check new applicants against a national database of disqualified individuals. (GAO, *Food Stamp Program: Households Collect Benefits for Persons Disqualified for Intentional Program Violations*, July 1999)

- **Food Stamps Given to Persons Disqualified for Failure to Meet Work Requirement** – The 1996 welfare reform law limits food stamp eligibility to 3 months out of a 36-month period for able-bodied, childless adults who work less than 20 hours per week. But after the law was enacted, 466 able-bodied Georgia residents

improperly received a total of $400,185 in food stamps, because the State failed to adequately monitor recipients for compliance with the work requirement. (Department of Agriculture IG Audit Report, *Food and Nutrition Service Administration of the Georgia Food Stamp Employment and Training Program*, September 1999)

< **Street Gang Steals Food Stamps** – Fourteen members of an Indiana criminal gang stole $728,000 worth of food stamps from four county welfare offices. The food stamps were traded to other gang members for cocaine, marijuana, and explosives. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Food Stamps Part of Welfare Scam** – In Indiana, four persons pled guilty to theft, forgery, and welfare fraud for their parts in a scheme to obtain unauthorized welfare benefits. The four represented themselves as food stamp recipients and used identification cards stolen from a county welfare office to obtain food stamps. There were 139 instances in which individuals implemented the scheme, obtaining a total of $57,600 in food stamps. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Murder for Food Stamps –** A serial killer collected welfare benefits, including food stamps, in 12 States between 1994 and 1996 under the assumed identities of his victims. He was a regular freight train rider and one of a gang whose members attack transients riding freight trains to obtain their food stamps. The man confessed to committing numerous homicides in several States – partly so he could use victims' identities to collect food stamps and other welfare benefits. A 1997 account in *The Washington Post* said murders and violent attacks against transients who ride freight trains increase during the period of the month in which food stamps are distributed. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **Food Stamp Recipients Receiving Multiple Benefits in Different States** – More than 20,000 persons simultaneously received food stamps in 1996 in at least two of four States surveyed. The duplicate recipients collected about $3.9 million in improper benefits over the course of the year. GAO made the findings by conducting a computer data match of food stamp recipients in the four States – California, Texas, Florida, and New York. (GAO, *Food Stamp Overpayments: Households in Different States Collect Benefits for the Same Individuals*, August 1998)

< **Food Stamps to Deceased Persons** – A total of $8.5 million in food stamps were paid out in 1995 and 1996 to 26,000 people, in four States, who were deceased – and it is unknown who redeemed the benefits. USDA only recently began addressing such problems, which occur because State agencies administering food stamps are not required to compare benefit rolls and death records. These particular cases were identified by surveying death records in the four States and matching them against households receiving food stamps. (GAO, *Food Stamp Overpayments: Thousands of Deceased Individuals Are Being Counted as Household Members*, February 1998)

< **An Inmate's False Application** – The 1996 welfare reform law made prisoners

ineligible for food stamps. But even after the law's enactment, a Virginia inmate falsely claimed he was living at home, and continued to receive food stamps there. His father, who participated in the fraud, collected and used the food stamps. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **Bogus Grocery Stores –** Two owners of a wholesale warehouse in Philadelphia hired people to open grocery stores authorized to accept food stamps. The bogus stores – which carried little inventory, and had no cash registers – then redeemed food stamps that had been illegally accepted as payment at 14 takeout restaurants. (By law, food stamps are to be used to buy groceries, not prepared meals.) The operation illegitimately obtained more than $15 million from the Food Stamp Program. The stores remained in business for 11 months. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1998)

< **Disqualified Vendor Returns to Program –** A Georgia grocer who had been disqualified from the Food Stamp Program on the basis of fraud sold his store to his sister, who was then authorized as a food stamp vendor. But the disqualified vendor continued to operate the store behind the scenes, and was caught purchasing $6,050 in food stamps from undercover operatives for $3,450 in cash. An investigation revealed the grocer had redeemed $4.5 million in food stamps over 4 years, even though the store was small and poorly stocked. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1998)

< **Postal Employee Steals Food Stamps –** In a single year, a Des Moines postal employee stole $27,160 in food stamps from monthly mailings while working at the general mail facility. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1998)

**Food Stamp Trafficking**

As noted above, food stamp trafficking generally begins when a vendor or other buyer accepts food stamps in exchange for cash at discounted rates. The food stamps then are exchanged with others, at increasing rates, until an authorized vendor redeems them.

Between 1990 and 1997, the Government identified food stamp trafficking in more than 5,700 retail stores. The IG investigated and reported on 5,551 cases, and the Department of Justice and State and local governments prosecuted 2,650 cases. (GAO, *Food Stamp Program: Information on Trafficking Food Stamp Benefits*, March 1998)

Trafficking problems have continued, as indicated by the following examples:

< **Drug Dealer Caught Trafficking Food Stamps** – The leader of a major Detroit drug-running operation, who had eluded prosecution for more than 20 years, was caught buying $23,000 in food stamps from an undercover police officer. (Department

of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Trafficker Attempts to Relocate** – A Warren, OH, retailer charged in December 1996 with laundering $2.2 million in food stamps fled prosecution and was located in Little Rock, AR, in February 1999, where he was attempting to buy new food stores. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Food Stamps Exchanged for Stolen Cars** – Seven Ohio residents exchanged food stamps for stolen automobiles and cash. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Trafficking in New York City** – A food stamp fraud investigation in New York City brought the indictment of 76 persons for unauthorized acceptance of food stamps for prepared foods, and redemption of the illegally acquired stamps by authorized food stamp vendors, who had purchased the stamps at below face value. Fifty-six defendants were convicted, and some were sentenced to up to 4 years in jail. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **"Commissions" for Trafficking** – Between January 1994 and July 1997, a Warrensville Heights, OH, grocer redeemed $6.1 million in food stamps for several Cleveland area grocers who were permanently disqualified from the Food Stamp Program. In return, the grocer received "commissions" of 4 percent to 5 percent. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **Trafficking From a "Rolling Store"** – Three Louisiana family members and their employee used their "rolling store" – a vehicle selling fruits and vegetables – primarily to buy food stamps at a cash discount. They fraudulently redeemed more than $1.3 million between 1993 and 1996. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **Trafficking Conspiracy** – Less than 3 months after being sentenced for prior food stamp violations, the owners of a Stockton, CA, market whose authorization had been withdrawn were found still to be illegally buying food stamps in return for cash. At the time, one of the owners was on a prison work-release program, and the other was on probation for convictions of food stamp trafficking violations committed between 1993 and 1995. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1997)

< **Trafficking in Milwaukee** – In Milwaukee County, WI, 44 authorized food stamp retailers were identified as potentially trafficking in food stamps because their food inventories did not support the amount of food stamps they had submitted to be redeemed. Another 27 were found to be ineligible because they did not meet the food inventory requirements, or had gone out of business. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1996)

**Problems in Electronic Benefits**

Electronic Benefits Transfer [EBT] has replaced food stamp coupons in 29 States. The EBT system, which is intended to reduce fraud and trafficking, provides food stamp benefits electronically through a magnetic debit card furnished to each recipient.

Implementing the system has caused problems in some areas. In Colorado, $730,000 in food stamps were issued to 10,000 ineligible persons due to a computer coding error in the State's EBT system. (Department of Agriculture IG Evaluation Report, *Food and Nutrition Service Strategic Monitoring of the Colorado EBT System Development Phase IV*, September 1999)

In addition, trafficking continues to occur when the cardholders accept cash, rather than food, charged against their EBT cards. Examples include the following:

< **Fraud by Phone** – A Baltimore liquor store owner whose store had been disqualified from the Food Stamp Program for trafficking was found to have continued trafficking in food stamp EBT benefits via telephone through three other stores authorized to accept food stamps. The program lost more than $544,000 through this additional trafficking. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Food Stamps Exchanged for Crack Cocaine** – Two Beaumont, TX, persons were convicted of trafficking in food stamp EBT benefits in exchange for crack cocaine. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1999)

< **Food Stamp Laundering** – In a $60-million food stamp fraud scheme, New York City takeout restaurants obtained food stamps at less than face value for prepared food, which is not eligible for food stamps. The takeout restaurants then sold the food stamps to small neighborhood groceries – also at less than face value – and the groceries cashed them at full value. Some of the groceries had reported only hundreds of thousands of dollars worth of annual grocery sales while cashing in millions of dollars in food stamps. (*The Associated Press*, 11 August 1998)

< **Trafficking at a Houston Market** – In Houston, TX, the owner of a sham meat and seafood market redeemed more than $331,000 in EBT food stamp benefits, even though virtually no food was purchased. The owner had also personally purchased EBT benefits for cash at a discounted rate from an undercover agent. The fraud occurred between March 1995 and April 1996. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

< **Trafficking at a Baltimore Grocery** – The owner of a Baltimore, MD, retail grocery admitted trafficking in $350,000 of EBT food stamp benefits through his store between 1992 and 1995. Five food stamp recipients who regularly trafficked their benefits at the store were indicted for fraud. (Department of Agriculture IG, *Semiannual Report to Congress*, May 1998)

## THE CHILD AND ADULT CARE FOOD PROGRAM [CACFP]

The Child and Adult Care Food Program [CACFP] provides meals and snacks to low-income children in child care, including those in home day care settings. It is run by State education departments, which – except in the State of Virginia – delegate management of the home day care program to "sponsors," who recruit providers to participate. The sponsors are reimbursed for the meals provided. The program – which serves about 2.6 million children and adults – is projected to spend about $1.6 billion in fiscal year 2000.

**How CACFP Is Abused**

Although each State receives a portion of $100 million to conduct oversight of the program's sponsors, few States have actually used their funds for oversight. Thus, the program relies on the trustworthiness of sponsors, and – because it is completely federally funded – States have no incentive to examine the sponsors for abuse. This contributes to the program's high vulnerability to fraud.

More significant, the Department of Agriculture's IG says program administrators have failed to correct problems in the program – despite warnings that date to 1995. Although the administration "had information showing problems existed," the IG said, "it had not acted aggressively to impose stronger controls." (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

In its most recent audit of the program, the IG explained how the design of the program is itself responsible for much of the fraud and abuse that takes place. As the IG put it:

> Under its current design, the CACFP has attracted opportunistic sponsors who have taken advantage of the programs's delivery system, a system that places the primary controls over the CACFP in the hands of the sponsors. Since this program can provide significant monetary gains, many sponsor organizations were created solely for the purpose of acquiring access to the program. While these sponsors have operated as nonprofit organizations, the incentives to enrich themselves at the expense of the program outweighed the goal of making sure that the CACFP is administered as intended: to feed children and adults in day care. This renders the program highly vulnerable to abuse. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

The IG first issued such warnings in 1995, and made a series of recommendations to correct them. These included establishing standards for approving and renewing sponsor organizations; strengthening regulations for terminating sponsors; and providing performance standards for reviewing sponsors' management plans. An administration task force later made similar recommendations, and subsequently a Presidential initiative called "Operation Kiddie Care" set out to track down fraud. Among the results were guilty pleas or convictions of 28 individuals charged with fraud. The indictment of one sponsor included 117 counts of fraud. One convicted sponsor official is serving a 3-year prison term, and another was sentenced to 9

years in prison.

But the fundamental reforms that the administration's own task force recommended have yet to be implemented. Says the IG: "The task force made recommendations to strengthen the CACFP. In our opinion, if these recommendations had been implemented, many sponsor abuses would have been prevented or detected." (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

**Examples of Abuse**

But abuses continue. Here are some recent examples:

< **Nearly Half of Providers Overclaim Reimbursements** – Of the 115 CACFP providers in the Quad County Child Nutrition Program in Decatur, AL, 53 overclaimed reimbursements totaling $3,088 for meals claimed to have been provided when investigators determined no children were present. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

< **Sponsor's Employee Embezzles $31,900** – An employee of Feeding Arizona Kids Inc. – a CACFP sponsor – wrote $31,900 in bogus reimbursement checks to nonexistent providers and deposited them in her own bank account for personal use. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

< **Sponsor Fails to Reimburse Providers** – Aladdin Child Care Services of Inglewood, CA, tried to drop out of the CACFP program while owing thousands of dollars in meal reimbursements to day care providers. Investigators determined Aladdin collected $800,000 in questionable costs and expenses while the majority of day care centers it sponsored were not reimbursed for meals they provided. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

< **Day Care Center Files False Claims** – A director of Kiddie Korner Kid Kare Inc., in the State of Idaho, was convicted of submitting false claims for CACFP funds totaling $83,000. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – Child and Adult Care Food Program: National Report on Program Abuses*, August 1999)

< **Inflated Budgets** – In California, a husband-and-wife sponsor team defrauded the program of $2.2 million by submitting inflated budgets and by diverting program funds

to themselves through "payments" to nonexistent employees and bogus entities. The couple also used numerous aliases to conceal their interest in the sponsoring organization. This was done in part because the wife was also a manager for the California State agency responsible for administering the CACFP program. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care": A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

< **Reimbursements for Meals Not Served** – A Utah sponsor defrauded the program of more than $100,000. One of the sponsor's providers, believed to be working in concert with the sponsor, claimed meal reimbursements when she had not provided meals to anyone. The provider implicated the sponsor in a scheme to demand and receive kickbacks from providers. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care" – A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

< **Reimbursements to Nonexistent Providers** – An Ohio sponsor claimed reimbursements for day care providers who did not exist. Seven persons, including the director of the sponsoring agency, set up at least 40 false providers. Claims submitted for the false providers resulted in improper reimbursements of more than $700,000 over 3½ years. The investigation uncovered money laundering through bank accounts set up in fictitious names, submission of false claims, making false statements, and mail fraud. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care" – A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

< **Sponsor Living Out of State** – In California, the executive director of a sponsor kept food reimbursement funds to cover the salary he claimed to earn in California while he was actually working for another enterprise and living in Wisconsin. He also had a vehicle in Wisconsin for his personal use that was paid for by the California CACFP. The IG questioned $231,000 in Federal payments to this individual. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care" – A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

< **Food Payments Embezzled** – A Louisiana sponsor embezzled food payments claimed for providers who were no longer providing day care but were kept on the sponsor's program rolls. The sponsor forged checks totaling about $28,000 for July through December 1997, and charged $18,000 in administrative costs. Investigations of the 125 homes administered by the sponsor showed poor oversight as well. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care" – A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

< **Payments for Incomplete, Unserved Meals** – In Florida, a sponsor used food funds to pay for more than $147,000 in questionable expenses. Large sums were paid to another enterprise with which the sponsor's director was affiliated. Visits to 207 day care homes showed the sites were unkempt and unclean. An estimated 30 percent of the provider's claims were questioned due to incomplete meals provided to children,

meals claimed for children not present, and meals claimed for children with no enrollment forms on file at the day care homes. (Department of Agriculture IG Interim Report, *Operation "Kiddie Care" – A Nationwide Sweep of the Child and Adult Care Food Program*, April 1998)

## OTHER CHILD NUTRITION PROGRAMS

### The School Lunch Program

The National School Lunch Program provides free or reduced price meals to low-income children. But it relies on families truthfully representing their incomes when applying for subsidized meals. Schools are required only to conduct random-sample spot checks averaging 5 percent of all applicants to verify the eligibility of recipients. Hence, there is little chance that persons misrepresenting their income will be caught; and when fraudulent applications are detected, the only penalty is loss of the child's eligibility for subsidized meals.

Because the program requires school districts to take a portion of the program as donated commodities rather than cash, school districts often obtain foodstuffs they neither want nor can use. In some cases, donated commodities were found spoiling because they were ordered in greater quantities than could be consumed before their expiration dates, or because they were stored at improper temperatures.

The program is estimated to spend $5.5 billion in fiscal year 2000.

### The Summer Feeding Program

The Summer Feeding Program essentially continues the mission of the National School Lunch and Breakfast Programs to provide meals to low-income children during the summer months when school is not in session. But the program shares a weakness with the Child and Adult Care Feeding program in that it is often administered by *sponsors*. In the absence of proper scrutiny, persons who wish to cheat the system can easily do so.

### Examples of Abuse

< **Puerto Rico School Lunch Program Overcharges** – The Commonwealth of Puerto Rico overcharged the Federal Government an estimated $23 million for its school lunch program. The Commonwealth failed to pay $11.5 million in its share of program expenses, which instead were billed to Washington. It also sought Federal reimbursement of the cost of providing free meals to all students – including middle-income and wealthy children – even though the Federal program provides free meals only to children from low-income households. (Department of Agriculture IG Audit Report, *Food and Nutrition Service: Puerto Rico Department of Education National*

*School Lunch and School Breakfast Programs,* September 1999)

< **Inflated Attendance Records –** The sponsor of the Pulaski County, AR, summer feeding program submitted $880,000 in overclaims between 1992 and 1995. The sponsor claimed it served an inflated number of meals than were actually served to children during the period. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1998)

< **Overcharge of $4.2 Million in DC** – In August 1995, the District of Columbia schools improperly transferred $1.7 million in special education personnel costs to its school lunch program, which had a $9-million balance at the time. In July 1996, the schools transferred $2.5 million in utility costs to the school lunch program. (Department of Agriculture IG Audit Report, *Food and Nutrition Service – National School Lunch and Breakfast Programs: District of Columbia*, August 1998)

< **Extended Storage** – The Milwaukee public schools had an 11-month supply of frozen ham for the school lunch program, even though the recommended storage period for frozen ham is only 6 months. At least 275,000 pounds of commodities valued at more than $246,000 were stored past their recommended usage periods. At one of the two Wisconsin warehouses, improper storage temperatures were identified 42 percent of the time in the two main freezers containing these commodities, risking spoilage. (Department of Agriculture IG Audit Report, *Food and Nutrition Service: National School Lunch Program and School Breakfast Program Controls Over USDA-Donated Commodities, Wisconsin*, February 1998)

< **Millions Wasted** – In Illinois, about $31.2 million in National School Lunch and Breakfast funds were wasted by reimbursing school districts for free and reduced price lunches and breakfasts served to people who were ineligible. That represented 19 percent of the $165.1 million spent on free and reduced price school lunches and breakfasts in Illinois. (Department of Agriculture IG Audit Report, *Food and Consumer Services: National School Lunch Program – Verification of Applications in Illinois*, August 1997)

< **False Claims for Reimbursement** – A Muskogee, OK, minister received $12,400 in unsupported or inflated payments in 1995 after he submitted false claims for reimbursement in the Summer Feeding Program. He admitted diverting almost $7,000 in program funds to his personal use. (Department of Agriculture IG, *Semiannual Report to Congress*, November 1997)

# SUPPLEMENTAL SECURITY INCOME

In its October 1999 report on the Government's financial management, the General Accounting Office [GAO] cited $1.6 billion worth of overpayments in 1998 in the Supplemental Security Income [SSI] Program. The General Accounting Office [GAO] had previously reported a similar $1.6 billion in overpayments in 1996. (GAO, *Supplemental Security Income: Opportunities Exist for Improving Payment Accuracy*, March 1998)

These substantial overpayments, in a program estimated to spend $29.3 billion in benefits in fiscal year 2000, are one reason GAO has designated SSI a "high-risk" program for the past 3 years – meaning it is exceptionally vulnerable to waste, fraud, abuse, and mismanagement. In addition, GAO reports that program administrators have chronically failed to recover outstanding overpayments, which now total about $4 billion. GAO blames these problems on the way in which SSI is run:

> To a great extent, SSA's inability to address its most significant longstanding SSI program weaknesses is attributable to two underlying causes: (1) an organizational culture that places a greater priority on processing and paying claims than on controlling program expenditures and (2) a management approach characterized by SSA's reluctance to fulfill its policy development and planning role in advance of major program crises. (GAO, *Major Management Challenges and Program Risks: Social Security Administration*, January 1999)

GAO reviewed a sample file of SSI beneficiaries to research characteristics of the program's population. GAO reported the following:

> SSI is inherently vulnerable to people who, with the help of others, feign their impairments to obtain benefits. Over 60 percent of SSI disability cases from an SSI statistical sample involved impairments that are difficult to objectively verify, and thousands of SSI recipients . . . used suspicious medical providers to gain access to the program. (GAO, *Supplemental Security Income: Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse*, September 1999)

The report was critical of the program's staff for not following procedures developed to deter fraud "because they believe the procedures conflict with agency work incentives that stress speed in processing claims and because they believe they are not adequately protected from legal liability that could arise if they were to follow claims denial procedures. They also question the agency's commitment to fighting fraud, since they repeatedly see the same suspicious middlemen and medical providers involved in SSI cases, despite previous referrals

for investigation." (GAO, *Supplemental Security Income: Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse*, September 1999)

The inspector general of the Social Security Administration [SSA] – which administers SSI – warned in a December 1998 report of the "inherent" risk of fraud in SSI. The IG wrote:

> Fraud vulnerability in the Supplemental Security Income [SSI] Program is a function of a number of complex factors such as SSA's reliance on self-reporting of income, living arrangements, and medical improvement; abusive practices of unethical interpreters, doctors, and attorneys; malingering to gain access to benefits; and unenforceable residence requirements. The SSI program continues to be considered a high-risk program by the General Accounting Office [GAO]. (Social Security Administration IG report to the House Majority Leader concerning SSA's Top 10 management problems, 4 December 1998)

The Supplemental Security Income Program was created in the early 1970s to assure a basic income level for needy individuals who are aged, blind, or disabled. In 1996, about 80 percent of the beneficiaries had physical or mental disabilities, and about 20 percent were elderly. Although SSI is administered by the Social Security Administration, *it is not part of Social Security and is not financed by the Social Security Trust Fund*; all of SSI's financing comes from the general fund.

Fraud and abuse in SSI involve more than a waste of taxpayers' dollars. They also drain resources intended for persons who need them.

The rest of this section gives further discussion of SSI's problems, and cites a series of specific examples of waste, fraud, and abuse in the program.

## SOURCES OF FRAUD AND ABUSE

A primary source of SSI fraud is the failure of many beneficiaries to disclose assets and other income that might disqualify them for benefits. In addition, certain persons who are ineligible for benefits – such as prisoners and people who no longer live in the United States – continue to receive benefits simply because they never notify program administrators that they have become ineligible.

Finally, some persons in nursing homes – whose benefit levels are supposed to be reduced to reflect the services they receive through Medicaid – never inform program administrators of their nursing home status. Hence, they continue to receive full benefits.

SSI relies mainly on applicants to truthfully disclose their financial resources and incomes. Caseworkers are trained to inquire further when suspect situations become apparent, but a thorough examination of eligibility occurs only for the small percentage of the caseload that is sampled statistically for the Office of Quality Assurance.

Behind these management weaknesses lies an "entitlement culture" in the program's staff, according to GAO. As GAO has noted in congressional testimony, staff members view their agency as an entity that processes applications for benefits and enrolls participants in the program, similar to its function in the Social Security Program. But GAO noted that SSI is a welfare program, not an earned benefit. Hence, benefit applications for SSI should be treated with the same scrutiny as applications for other welfare benefits. With welfare, it is assumed that some applicants willfully mislead the agency to fraudulently obtain benefits. In lacking this basic skepticism, SSI staff members open the door for significant levels of fraud and overpayments, GAO says.

Program administrators also fail to use tools – such as fines and full withholding of permissible recoveries from future benefit checks – that discourage misrepresentation. Such preventive measures are important, because once an overpayment is made, it is exceptionally difficult to recover – due to the low incomes of SSI beneficiaries.

## EXAMPLES OF ABUSE

The examples of abuses below were compiled from information by GAO, the Social Security Administration's IG, and other sources. These illustrations reflect only episodes of abuse that have been uncovered, often after lengthy investigation. As long as the systemic management problems remain, such incidents are likely to keep occurring.

< **Fugitive Felons Receiving Benefits** – The Social Security Administration identified 5,898 fugitive felons who were illegally receiving SSI payments between April 1, 1999, and September 30, 1999. The felons had collected a total of $10.5 million in benefits. (Social Security Administration IG, *Semiannual Report to the Congress*, September 1999)

< **Employee of Representative Payee Embezzles Benefits** – An employee of a company that served as a representative payee for SSI recipients embezzled $55,000 in SSI benefits. (Social Security Administration IG, *Semiannual Report to the Congress*, September 1999)

< **One-Person Crime Wave** – A woman who was receiving SSI payments for herself and acting as representative payee for three children and one grandchild was found to have received $5,890 in disability payments on behalf of a grandchild who was not really in her care. Additionally, she had wrongfully received $21,195 in benefits by failing to report child support she was receiving on behalf of two of her children who were also receiving SSI; receiving $25,425 in benefits on her own behalf while failing to report other sources of income; and wrongfully receiving $2,681 by claiming she had not received SSI benefit checks for herself and her children – when she had in fact received both those checks and the replacement checks simultaneously. (Social Security Administration IG, *Semiannual Report to the Congress*, September 1999)

< **Illegal Alien Gets SSI** – An illegal alien used a fraudulent birth certificate to obtain

welfare and Medicaid benefits. She also applied for and received more than $100,000 in SSI benefits, although she admitted to knowing she was ineligible for these benefits. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1999)

< **SSI Beneficiary Collects Second Benefit** – A qualified SSI recipient collected more than $90,000 in additional illegal benefits from 1974 through 1998 under his brother's name. He used the money to pay personal expenses for himself and his girlfriend. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1999)

< **SSI Disability Recipient Found Working** – A 29-year old SSI recipient claimed total disability resulting from hepatitis. During disability examinations with physicians and a psychiatrist, she repeatedly gave nonsensical answers. Nevertheless, the claimant qualified to become a school bus driver and held a commercial driver's license, which required successful completion of a 4-week training course and a physical examination – during which the recipient professed to be healthy and suffering from no physical, mental, or emotional problems which would impair her operation of a school bus. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1999)

< **Roommate of Deceased SSI Recipient Collects Benefits** – An SSI recipient died in 1993, but the recipient's roommate and another acquaintance – using an automatic teller machine – withdrew SSI benefits totaling $35,040 that continued to be deposited for several years in the deceased roommate's bank account. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1999)

< **Nonresidents Obtain SSI Benefits** – Nine residents of Mexico obtained at least $128,653 in fraudulent SSI benefits by maintaining maildrop addresses in Laredo, TX. The fraud stretched over several years until detected in January 1999. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1999)

< **Middleman Fraud –** A Washington State founder of a Buddhist temple acted as middleman to fraudulently obtain $1 million in SSI benefits for 50 people associated with the temple. The man charged the beneficiaries up to $3,000 per case for assisting them to fraudulently apply for benefits. (Social Security Administration IG, *Semiannual Report to the Congress*, November 1998)

< **Concealed Rental Income –** A Massachusetts couple illegally collected SSI benefits from 1992 through 1998 while at the same time collecting $2,500 per month in rental income, although at the time they applied for benefits, they claimed they were receiving no rental income. (Social Security Administration IG, *Semiannual Report to the Congress*, November 1998)

< **Representative Payee Steals Benefits –** The chief executive officer of a fee-for-

service representative payee – who was responsible for receiving SSA and SSI benefit payments for persons declared incompetent by court order – stole $1.25 million in benefits that should have gone to 330 beneficiaries in Arizona and Colorado during a 14-month period. (Social Security Administration IG, *Semiannual Report to the Congress*, November 1998)

< **Abusive Parents Steal Benefits –** Two Michigan parents, who had their children lie to SSA medical consultants about their medical conditions, collected $42,639 in fraudulent benefits as representative payees for their children. Meanwhile, they locked the children in the basement of their home, physically abused them, and forced them to steal for them. (Social Security Administration IG, *Semiannual Report to the Congress*, November 1998)

< **Convicted Murderer Receiving Benefits** – Although convicted felons in prison are not eligible for SSI benefits, mass murderer William Bonin, California's infamous "freeway killer," received more than $75,000 in SSI disability benefits due to his claim of mental illness during his 14 years awaiting execution. His mother used the benefits to pay off her mortgage. The payments stopped only after Bonin's 1996 execution, when paperwork on his death was filed by the funeral director. (*Associated Press*, 6 August 1998)

< **Fugitives Collecting Benefits** – Although fugitives are not eligible for SSI benefits, 18 convicted felons who had escaped from prison collected $330,000 in benefit payments while in flight from the law. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1997)

< **Benefits Illegally Paid to Nonresidents –** In El Paso, TX, 156 persons – out of a sample of 2,107 – illegally received $1.6 million in SSI benefits while they were living in Mexico. People living outside the United States are not eligible for SSI benefits. (Social Security Administration IG, *Semiannual Report to the Congress*, March 1997)

# THE EARNED INCOME CREDIT

The Earned Income Credit [EIC] is a $29-billion tax credit program for low-income workers. The credit is refundable – meaning persons who are eligible receive the credit in a refund check if they pay no taxes.

The credit (previously called the Earned Income Tax Credit, or EITC) was created as an incentive for low-income workers to remain in the work force in the face of mounting payroll taxes. Over time, however, the value of the credit has been expanded. Because the credit relies on taxpayer-provided information, the program is highly subject to fraud.

> Massive EITC scams have been identified in the past and have included conspiracies in which hundreds of taxpayers' Social Security numbers [SSN] were used by perpetrators of fraud. . . . [T]he latest (1995 tax returns) and best available indicator of the EITC overpayment rates suggests a 32.08 to 34.28 percent overpayment rate, which translates into inappropriate payments in excess of $8 billion per year. (Department of the Treasury IG, *Fiscal Year 2000 Major Management Challenges Facing the Internal Revenue Service*, 1 December 1999)

An IRS audit of returns claiming the EIC for tax year 1994 found $4.4 billion in overpayments – out of $17.2 billion in total claims. A followup study by the IRS determined that, even after the implementation of compliance reforms, the error rate was still at least 20 percent of all EIC claims filed. (GAO, *Major Management Challenges and Program Risks: Department of the Treasury*, January 1999.)

More recent accounts show the program is still subject to high levels of fraud and abuse. The General Accounting Office [GAO] offers the following assessment:

> During fiscal year 1998, IRS reported that it processed EITC claims totaling over $29 billion, including over $23 billion (79 percent) in refunds. Of the 290,000 EITC tax returns with indications of errors or irregularities that IRS examiners reviewed, $448 million (68 percent of the $662 million claimed) was found to be invalid during fiscal year 1998. The IRS has not disclosed any estimated improper payments in its financial statement reports. (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999)

The tax auditing process necessarily looks at back returns to verify accuracy of Internal Revenue Service [IRS] refunds. Hence, there is a substantial time lag before investigators can

verify abuses; and obtaining current information about abuse of the credit is difficult. Some of the examples below reflect this time lag. Nevertheless, the examples indicate some of the ways in which the EIC can be abused, as well as some of the reasons.

< **IRS Procedures Contribute to EIC Problems** – According to GAO, efforts by the Internal Revenue Service to emphasize speedy service to tax filers contribute to improper payments to filers who fraudulently claim Earned Income Credit refunds. GAO notes that the IRS is mandated to process tax refunds within 45 days of receipt of a tax return. If the refund is not processed within that time, IRS must pay interest to the taxpayer. Because examinations of tax returns claiming the EIC are often performed after any related refunds are paid out, these examination are less efficient and effective than preventive controls designed to identify invalid claims before refunds are made. "Even in cases where IRS has identified potentially erroneous claims," GAO said, "it released refunds prior to completing the reviews. (GAO, *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments*, October 1999.)

< **Border Town a Fraud Capital** – A Phoenix, AZ, IRS examiner detected a scheme to defraud the EIC in the border town of San Luis. Although the town has only 3,500 residents, more than 13,500 tax returns were filed in 1994 claiming the town as the filer's residence. Of those, 10,000 claimed refunds under the EIC. According to the IRS examiner: "Most of the people filing tax returns there did not qualify for the credit" because they did not even live in the United States. They were citizens of Mexico who crossed the border to defraud the program. (*The National Law Journal*, 25 October 1999.)

< **Prison Inmates File False Returns, Receive Earned Income Credit Payments** – Seven inmates at the District of Columbia's Lorton Prison obtained EIC payments of $722 each by filing phony tax returns claiming income earned from jobs such as "barber" and "coal miner" when, in fact, they had been incarcerated the entire year and had no earned income. The scam was detected only after employees in the prison's mail room found it strange that prisoners were getting tax refunds, and reported it to authorities. (*The Washington Post*, 5 April 1997.)

< **Dishonest Tax Preparers Rip Off the EIC** – Eleven tax preparers who operated businesses targeting low-income persons living in communities on the California-Mexico border were accused by the IRS of defrauding the Government of more than $15 million. The tax preparers encouraged ineligible persons, mostly Mexican migrant workers, to file fraudulent tax returns claiming the Earned Income Credit. The tax preparers then charged the filers fees, which were deducted from the filers' EIC refunds. The IRS announced that it would not prosecute the persons who were lured into filing the false returns, but would try to find them to recover the misappropriated funds. The IRS also admitted that it was unlikely much of the money would be recovered, due to the transient nature of the filers. (*The San Diego Union*, 6 April 1998.)

## ADDENDUM
# FRAGMENTATION AND DUPLICATION

### INTRODUCTION

The problems of fragmented and duplicative Government activities is strikingly reflected in what might be termed the "pizza regulations." GAO explains as follows:

> As many as 12 different Federal agencies administer over 35 different laws overseeing food safety. To underscore the fragmentation, subtle differences in food products dictate which agency regulates a product. For example, USDA is responsible for inspecting food plants that produce open-faced meat sandwiches and pizzas with a meat topping, whereas the Department of Health and Human Services' [HHS] Food and Drug Administration is responsible for inspecting food plants that produce traditional meat sandwiches and nonmeat pizzas. (GAO, *Major Management Challenges and Program Risks: A Governmentwide Perspective*, January 1999)

GAO also explains succinctly why these problems are harmful.

> In program after program, we have found that unfocused and uncoordinated crosscutting programs waste scarce funds, confuse and frustrate taxpayers and other program customers, and limit overall program effectiveness. (GAO, *Major Management Challenges and Program Risks: A Governmentwide Perspective*, January 1999)

Other areas of fragmentation and overlap in the Federal Government include the following:

### Economic Development

GAO has identified 342 different economic development-related programs, and has said: "Some programs, such as those managed by the Economic Development Administration [EDA], the Appalachian Regional Commission [ARC], and the Department of Housing and Urban Development [HUD] are similar enough to be potential candidates for merger or elimination." (GAO, *Reassessing What the Federal Government Does*, 1 November 1999)

## The Department of Commerce

The Department today shares missions with at least 71 other Federal departments, agencies, and offices. GAO has characterized the Department as "a large 'holding company' composed of 12 operating bureaus, each pursuing disparate programs and activities that cut across several Federal functions." (GAO, *Major Management Challenges and Program Risks: Department of Commerce*, January 1999)

Budget resolutions in both the 104th and 105th Congresses called for eliminating the Department.

## Education

The comprehensive *Education at a Crossroads* project, by members of the Committee on Education and the Workforce, initially found more than *760 Federal education programs*. After further evaluation, the committee found the total list of Federal education programs grew to 788 programs, spanning at least 39 Federal agencies, boards, and commissions, and costing roughly $100 billion a year [see table and graphic on the next two pages]. (The committee used information from the Office of Management and Budget [OMB], the Catalog of Federal Domestic Assistance [CFDA], the Congressional Research Service [CRS], and the individual agencies that administer Federal education programs.)

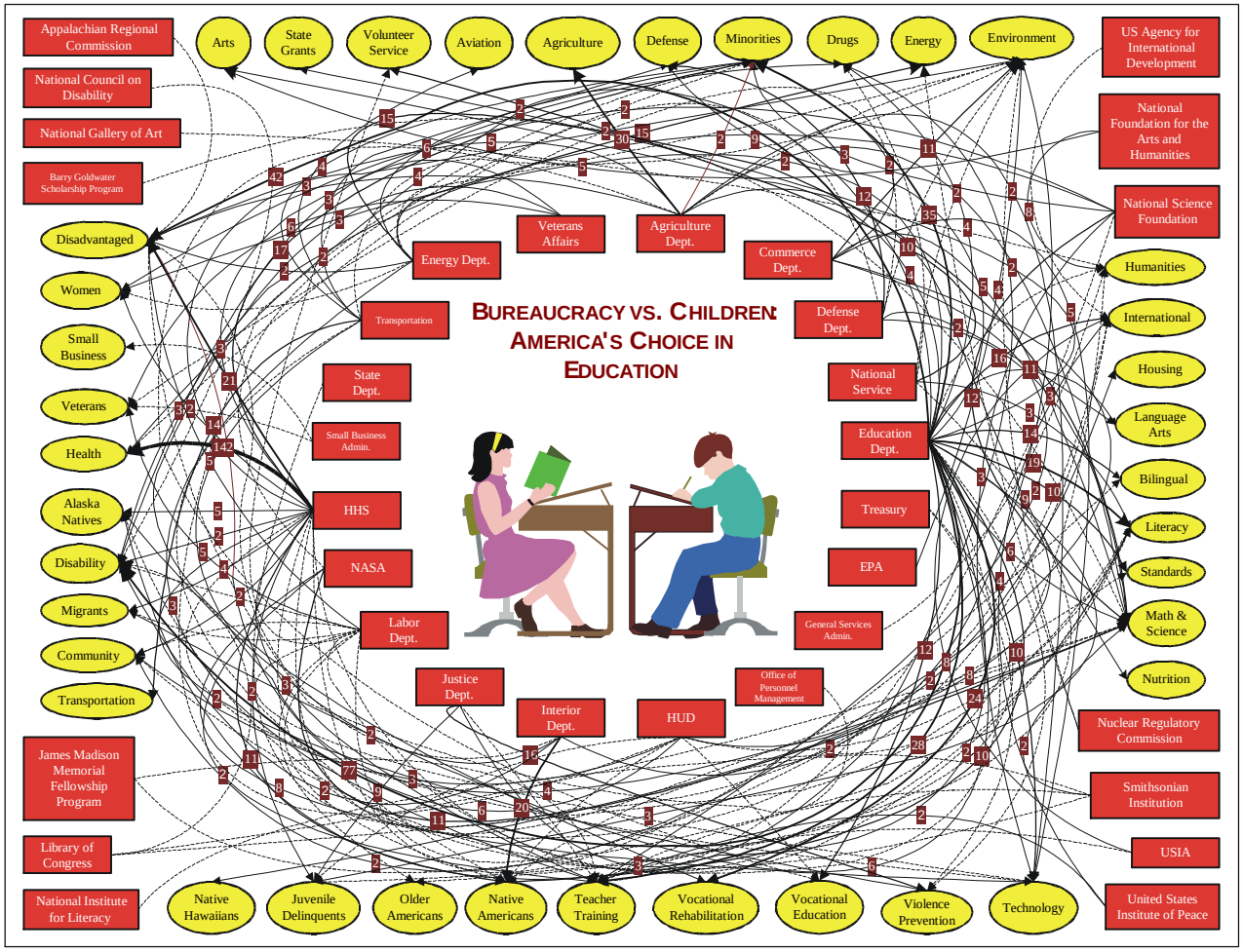
The *Education at a Crossroads* project added:

> Additional evidence of duplication and overlap is evident in that many Cabinet agencies have their own education offices. For example, despite the existence of 63 math and science programs, the Department of Energy has a division devoted to "Education in Science, Technology, Engineering, and Math." The division provides curriculum support, teacher training, and other scientific information. The Department recently announced the creation of a new "education task force" devoted to determine how it can best enhance science, math, and technology education, as well as providing schools with access to its scientific, technological, and supercomputing resources. (House Education and the Workforce Sub-committee on Oversight and Investigations, *Education at a Crossroads: What Works and What's Wasted in Education Today*, 17 July 1998)

The report also said: "[T]here are many other examples of overlapping programs between agencies, and although attempts have recently been made to consolidate some duplicative programs, much work remains to be done." (House Education and the Workforce Subcommittee on Oversight and Investigations, *Education at a Crossroads: What Works and What's Wasted in Education Today*, 17 July 1998)

| AGENCY | PROGRAMS | 1997 SPENDING |
|---|---|---|
| Appalachian Regional Commission | 2 | $2,000,000 |
| Barry Goldwater Scholarship Program | 1 | $2,900,000 |
| Christopher Columbus Fellowship Program | 1 | $0 |
| Corporation for National Service | 11 | $501,130,000 |
| Department of Education | 307 | $59,045,043,938 |
| Department of Commerce | 20 | $156,455,000 |
| Department of Defense | 15 | $2,815,320,854 |
| Department of Energy | 22 | $36,700,000 |
| Department of Health and Human Services | 172 | $8,661,006,166 |
| Department of the Treasury | 1 | $11,000,000 |
| Department of Interior | 27 | $555,565,000 |
| Department of Housing and Urban Development | 9 | $81,800,000 |
| Department of Justice | 21 | $755,447,149 |
| Department of Labor | 21 | $5,474,039,000 |
| Department of Transportation | 19 | $121,672,000 |
| Department of Veterans Affairs | 6 | $1,436,074,000 |
| Environmental Protection Agency | 4 | $11,103,800 |
| Federal Emergency Management Administration | 6 | $118,512,000 |
| General Services Administration | 1 | $0 |
| Government Printing Office | 2 | $24,756,000 |
| Harry Truman Scholarship Foundation | 1 | $3,187,000 |
| James Madison Memorial Fellowship Program | 1 | $2,000,000 |
| Library of Congress | 5 | $194,822,103 |
| National Aeronautics and Space Administration | 12 | $153,300,000 |
| National Archives | 2 | $5,000,000 |
| National Institute for Literacy | 1 | $4,491,000 |
| National Council on Disability | 1 | $200,000 |
| National Endowment for the Arts/Humanities | 13 | $103,219,000 |
| National Science Foundation | 15 | $2,939,230,000 |
| Nuclear Regulatory Commission | 3 | $6,944,000 |
| National Gallery of Art | 1 | $750,000 |
| Office of Personnel Management | 1 | $0 |
| Small Business Administration | 2 | $73,540,000 |
| Smithsonian | 14 | $3,276,000 |
| State Department | 1 | $0 |
| United States Information Agency | 8 | $125,558,000 |
| United States Institute for Peace | 4 | $3,371,000 |
| United Stated Department of Agriculture | 33 | $13,339,630,410 |
| U.S. Agency for International Development | 1 | $14,600,000 |
| Social Security Administration | 1 | $85,700,000 |

Source: Education at a Crossroads. Note: This table includes all authorized programs, including student lending programs). See also: U.S. Department of Education, *Digest of Education Statistics*, 1997, Tables 358-9.


BUREAUCRACY VS. CHILDREN:
AMERICA'S CHOICE IN
EDUCATION
Appalachian Regional Commission
National Council on Disability
National Gallery of Art
Barry Goldwater Scholarship Program
James Madison Memorial Fellowship Program
Library of Congress
National Institute for Literacy
Arts
State Grants
Volunteer Service
Aviation
Agriculture
Defense
Minorities
Drugs
Energy
Environment
US Agency for International Development
National Foundation for the Arts and Humanities
National Science Foundation
Humanities
International
Housing
Language Arts
Bilingual
Literacy
Standards
Math & Science
Nutrition
Nuclear Regulatory Commission
Smithsonian Institution
USIA
United States Institute of Peace
Technology
Violence Prevention
Vocational Education
Vocational Rehabilitation
Teacher Training
Native Americans
Older Americans
Juvenile Delinquents
Native Hawaiians
Disadvantaged
Women
Small Business
Veterans
Health
Alaska Natives
Disability
Migrants
Community
Transportation
Veterans Affairs
Agriculture Dept.
Commerce Dept.
Defense Dept.
National Service
Education Dept.
Treasury
EPA
General Services Admin.
Office of Personnel Management
HUD
Interior Dept.
Justice Dept.
Labor Dept.
NASA
HHS
Small Business Admin.
State Dept.
Transportation
Energy Dept.

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